

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK
ROCHESTER DIVISION

Jennifer Lyn Brown

Plaintiff

vs.

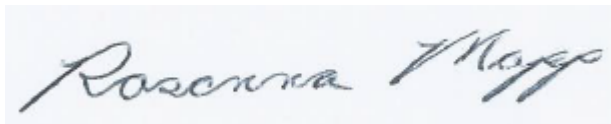
KILOLO KIJAKAZI
ACTING COMMISSIONER OF
SOCIAL SECURITY

Defendant

CIVIL ACTION NO.
6:21-CV-06189-UNA

CERTIFICATION

The undersigned, as Chief, Court Case Preparation and Review Branch 3, Office of Appellate Operations, Social Security Administration, hereby certifies that the documents annexed hereto constitute a full and accurate transcript of the entire record of proceedings relating to this case.



ROSANNA MAPP

DATE: July 28, 2021

Note: This certified administrative record is not text-searchable because the Office of Analytics, Review, and Oversight currently lacks the technology to create a text-searchable record. Any record saved in or converted to another format in an attempt to make the record text-searchable has not been certified.

Court Transcript Index

Civil Action Number: 6:21-CV-06189
 Claimant: Jennifer Lyn Brown
 Account Number: 132-58-2507

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The documents and exhibits contained in this administrative record are the best copies obtainable.

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Claimant: Jennifer Lyn Brown

Account Number: 132-58-2507

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The documents and exhibits contained in this administrative record are the best copies obtainable.



SOCIAL SECURITY ADMINISTRATION

Refer to: Jennifer Lyn Brown

Office of Appellate Operations
5107 Leesburg Pike
Falls Church, VA 22041-3255
Telephone: (877) 670-2722
Date: January 5, 2021

NOTICE OF APPEALS COUNCIL ACTION

Ms. Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

This is about your request for review of the Administrative Law Judge's decision dated August 7, 2020. You submitted reasons that you disagree with the decision. We considered the reasons and exhibited them on the enclosed Order of the Appeals Council. We found that the reasons do not provide a basis for changing the Administrative Law Judge's decision.

We Have Denied Your Request for Review

We found no reason under our rules to review the Administrative Law Judge's decision. Therefore, we have denied your request for review.

This means that the Administrative Law Judge's decision is the final decision of the Commissioner of Social Security in your case.

Rules We Applied

We applied the laws, regulations and rulings in effect as of the date we took this action.

Under our rules, we will review your case for any of the following reasons:

- The Administrative Law Judge appears to have abused his or her discretion.
- There is an error of law.
- The decision is not supported by substantial evidence.
- There is a broad policy or procedural issue that may affect the public interest.
- We receive additional evidence that you show is new, material, and relates to the period on or before the date of the hearing decision. You must also show there is a reasonable probability that the additional evidence would change the outcome of the decision. You

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

must show good cause for why you missed informing us about or submitting it earlier.

Additional Evidence

You submitted a statement from Dr. Michael Georgetson dated September 22, 2020 (3 pages) and a statement and records from Dr. James Freeman dated September 23, 2020 to October 7, 2020 (6 pages). The Administrative Law Judge decided your case through August 7, 2020. This additional evidence does not relate to the period at issue. Therefore, it does not affect the decision about whether you were disabled beginning on or before August 7, 2020.

If you want us to consider whether you were disabled after August 7, 2020, you need to apply again. If you file a new claim for disability insurance benefits within 6 months after you receive this letter, we can use September 22, 2020, the date of your request for review, as the date of your new claim. The date you file a new claim can make a difference in the amount of benefits we can pay.

You have the right to file a new application at any time, but filing a new application is not the same as filing a civil action. If you disagree with our action and file a new application instead of filing a civil action, you might lose some benefits or not qualify for any benefits. So, if you disagree with our action, you should file a civil action within 60 days as described below.

If You Disagree With Our Action

If you disagree with our action, you may ask for court review of the Administrative Law Judge's decision by filing a civil action.

If you do not ask for court review, the Administrative Law Judge's decision will be a final decision that can be changed only under special rules.

How to File a Civil Action

You may file a civil action (ask for court review) by filing a complaint in the United States District Court for the judicial district in which you live. The complaint should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this letter.

You or your representative must deliver copies of your complaint and of the summons issued by the court to the U.S. Attorney for the judicial district where you file your complaint, as provided in rule 4(i) of the Federal Rules of Civil Procedure.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Social Security Administration's Office of the General Counsel that is responsible for the processing and handling of litigation in the particular judicial district in which the complaint is filed. The names, addresses, and jurisdictional responsibilities of these offices are published in the Federal Register (70 FR 73320, December 9, 2005), and are available on-line at the Social Security Administration's Internet site,

<http://policy.ssa.gov/poms.nsf/links/0203106020>.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Attorney General of the United States, Washington, DC 20530.

Time To File a Civil Action

- You have 60 days to file a civil action (ask for court review).
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period.
- If you cannot file for court review within 60 days, you may ask the Appeals Council to extend your time to file. You must have a good reason for waiting more than 60 days to ask for court review. You must make the request in writing and give your reason(s) in the request.

You must mail your request for more time to the Appeals Council at the address shown at the top of this notice. Please put the Social Security number(s) also shown at the top of this notice on your request. We will send you a letter telling you whether your request for more time has been granted.

About The Law

The right to court review for claims under Title II (Social Security) is provided for in Section 205(g) of the Social Security Act. This section is also Section 405(g) of Title 42 of the United States Code.

The right to court review for claims under Title XVI (Supplemental Security Income) is provided for in Section 1631(c)(3) of the Social Security Act. This section is also Section 1383(c) of Title 42 of the United States Code.

The rules on filing civil actions are Rules 4(c) and (i) in the Federal Rules of Civil Procedure.

If You Have Any Questions

If you have any questions, you may call, write, or visit any Social Security office. If you do call or visit an office, please have this notice with you. The telephone number of the local office that serves your area is (866)964-1715. Its address is:

Social Security Admin
3345 Chambers Rd
Suite 19
Horseheads, NY 14845-0000

Jennifer Lyn Brown (132-58-2507)

Page 4 of 4

/s/ *Aimee E. Durel*

Aimee E. Durel
Appeals Officer

Enclosure: Order of Appeals Council

cc: Peter Gorton
1500 E. Main St
PO Box 89
Endicott, NY 13761-0089

Jennifer Lyn Brown
Claimant

132-58-2507
Social Security Number

Wage Earner

Social Security Number

AC EXHIBITS LIST

<u>EXHIBIT NO.</u>	<u>DESCRIPTION</u>	<u>NO. OF PAGES</u>	<u>COURT TRANSCRIPT PAGE NO.</u>
Exhibit B13B	Request for Review from Peter Gorton received 09/22/2020 (3 pages).		
Exhibit B16E	Representative Brief dated September 22, 2020 (1 page).		

Social Security Administration
OFFICE OF APPELLATE OPERATIONS

ORDER OF APPEALS COUNCIL

IN THE CASE OF

Jennifer Lyn Brown
(Claimant)

(Wage Earner)

CLAIM FOR

Period of Disability
Disability Insurance Benefits

132-58-2507

(Social Security Number)

The Appeals Council has received additional evidence which it is making part of the record.
That evidence consists of the following exhibits:

Exhibit B13B Request for Review from Peter Gorton received
09/22/2020 (3 pages).

Exhibit B16E Representative Brief dated September 22, 2020 (1
page).

Date: January 5, 2021

Peter Gorton
1500 E. Main St
PO Box 89
Endicott, NY 13761-0089

LACHMAN & GORTON
Attorneys At Law

EDWIN LACHMAN (1923-2012)
PETER A. GORTON

RICHARD F. MIHALKOVIC
DOROLLO NIXON, JR.

1500 East Main Street
P. O. Box 89
Endicott, New York 13761-0089

e-mail: office@lglaw.org

PHONE: (607) 754-0500
FAX: (607) 748-6978 (General)
FAX: (607) 484-2132 (Real Estate)
Express Mail: 1500 E. Main Street
Endicott, NY 13760

September 26, 2020

Social Security Administration
Office of Disability Adjudication & Review
Appeals Council
5107 Leesburg Pike Ste 1400
Falls Church, VA 22041- 3255
Certified Mail

Re: Jennifer Brown
SSN: 132-58-2507
DOB: 10/26/1976

Dear Sir/Madam:

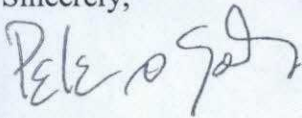
In connection with matter in which we did not represent the Claimant but were retained after the hearing, we prepared the attached Questionnaire.

The Treating Doctor Michael Georgetson has completed the 2 page Questionnaire relating to the stomach issues which we enclose.

Please incorporate this into the claimant's file.

Thank you for your kind attention.

Sincerely,



Peter Gorton
Enclosure

cc: Jennifer Brown

QUESTIONNAIRE

Re: Jennifer Brown
SSN: 132-58-2507
DOB: 10/26/1976

1. Please indicate the conditions and the diagnoses for the conditions for which you treat the above named and indicate the objective findings, clinical findings, and credible subjective symptomology establishing the diagnoses.

Gastroesophageal Reflux Disease Based on Endoscopic Findings and History

Crohn's Disease of the Small Intestine Based upon History, CT Findings, Endoscopic Findings, Biopsy Results

2. Please indicate whether the medical conditions above would affect the claimant's need to be near a bathroom at work by either checking one of the answers or writing your own assessment.

YES NO

- A. Medical conditions suffered by the claimant would require unlimited access to the bathroom

☒ ☐

-OR-

- B. The need to use the bathroom could be accommodated in a job which allowed for a break in the morning, a break in the afternoon and a break for lunch

☐ ☐

3. Please indicate whether there would be urgency with the need to use the bathroom again either by indicating the answer to one of the questions or again setting forth your own

YES NO

- A. The need to use the bathroom would be urgent and immediate

☒ ☐

-OR-

- B. The need to use the bathroom would not be urgent or immediate and could be accommodated by standard breaks in the morning and afternoon and at lunch

☐ ☐

4. Off Task

A. Please give your medical opinion as to whether the conditions set forth hereinabove and/or any side effects of medication would have the following effects:

- a. Would they cause pain to your patient? Yes ☒ No ☐
- b. Would they cause fatigue to your patient? Yes ☒ No ☐
- c. Would the conditions, the pain from the conditions and/or side effects of medication diminish concentration? Yes ☒ No ☐
- d. Would the conditions, the pain from the conditions and/or side effects of medication diminish work pace? Yes ☒ No ☐
- e. Would the conditions cause your patient to need to rest at work? Yes ☒ No ☐

5. OFF TASK - If the need to use the restroom or any pain, fatigue, diminished concentration or diminished work pace from the conditions would cause your patient to be "OFF TASK" at work, please indicate your opinion as to whether the patient would be "OFF TASK":

☐ 10% or less

☐ More than 10% but less than 15%

☒ More than 15% but less than 20% (Estimate as the disease activity may vary)

☐ Greater than 20% but less than 33%

☐ More than 33% of the day

6. Absenteeism

A. Would the conditions be expected to produce good days and bad days for your patient?

Yes ☒ No ☐

B. If yes, please indicate whether the bad days would lead to missed time from work per month:

☐ 1 day or less per month

☐ 2 days per month

☒ 3 days per month (Estimate as Disease Activity may vary)

☐ 4 days per month

☐ More than 4 days per month

7. Based on history, your examinations, review of medical records of patient and objective, clinical and consistent subjective finding, what is the time period the answers herein represent?

5/23, 2015 to 7/20, 2016

Date: 8/22/2020

Signature: Michael Georgeffon

Michael Georgeffon, MD

LACHMAN & GORTON
Attorneys At Law

EDWIN LACHMAN (1923-2012)
PETER A. GORTON

1500 East Main Street
P. O. Box 89
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Express Mail: 1500 E. Main Street
Endicott, NY 13760

RICHARD F. MIHALKOVIC
DOROLLO NIXON, JR.

e-mail: office@lglaw.org

October 10, 2020

Appeals Council
5107 Leesburg Pike Ste 1400
Falls Church, VA 22041- 3255
Attn: Branch 7, Suite 1003
Via Fax (877) 310-0025

Re: Jennifer Brown
SSN: 132-58-2507
DOB: 10/26/1976

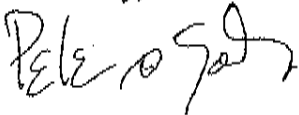
Dear Sir/Madam:

Treating source James Freeman, MD was kind enough to take valuable time from his schedule to complete the answers on the questionnaire prepared by our firm.

We enclose the questionnaire dated October 7, 2020 consisting of 3 pages along with 2 page Medication List.

Thank you for your kind attention.

Sincerely,



Peter Gorton
PG/cw

Enclosure

Oct 08 2020 10:14AM Guthrie 5708872327

page 2

OCT/03/2020/SAT 02:16 PM

FAX No.

P. 002

340616

Oct 01 2020 03:21PM Guthrie 5708872327

page 4

SEP/22/2020/TUE 09:40 AM

FAX No.

P. 003/005

QUESTIONNAIRE

Re: Jennifer Brown
 SSN: 132-55-2507
 DOB: 10/26/1976

1. Please indicate the conditions and the diagnoses for the conditions for which you treat the above named and indicate the objective findings, clinical findings, and credible subjective symptomology establishing the diagnoses.

FOR THE BALANCE OF THE QUESTIONS HEREIN, PLEASE STATE YOUR ANSWERS BASED UPON THE LIMITATIONS (IF ANY) THAT THE PATIENT SUFFERS FROM WHICH ARE CONSISTENT WITH THE MEDICAL CONDITION OF THE PATIENT.

2. Off Task

- A. Please give your medical opinion as to whether the conditions set forth hereinabove and/or any side effects of medication would have the following effects:

- a. Would they cause pain to your patient? Yes ☒ No ☐
 b. Would they cause fatigue to your patient? Yes ☒ No ☐
 c. Would the conditions, the pain from the conditions and/or side effects of medication diminish concentration? Yes ☒ No ☐
 d. Would the conditions, the pain from the conditions and/or side effects of medication diminish work pace? Yes ☒ No ☐
 e. Would the conditions cause your patient to need to rest at work? Yes ☒ No ☐

- B. If one or more of the answers above were yes, please indicate whether the pain, fatigue, diminished concentration or work pace or need to rest would lead your patient to be OFF TASK during a work day, please give your best medical opinion as to the time OFF TASK:

- ☐ 10% or less
☐ More than 10% but less than 15%
☐ More than 15% but less than 20%
☐ Greater than 20% but less than 33%
☒ More than 33% of the day

3. Absenteeism

- A. Would the conditions be expected to produce good days and bad days for your patient?

Yes ☒ No ☐

Oct 08 2020 10:14AM Guthrie 5708872327

page 3

OCT/03/2020/SAT 02:17 PM

FAX No.

P. 003

340616

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page 5

SEP/22/2020/TUE 09:40 AM

FAX No.

P. 004/005

B. If yes, please indicate whether the bad days would lead to missed time from work per month:

☐ 1 day or less per month
 ☒ 2 days per month
 ☐ 3 days per month
☐ 4 days per month
 ☒ More than 4 days per month

4. A. State the medications currently being taken by the claimant.

B. State side effects, if any, of said medications (Specifically indicate if any medications cause fatigue or require the patient to rest after taking same).

5. Please complete the physical capacities evaluation herein.

A. If sitting is impacted by claimant's condition, indicate how many hours the patient can sit out of an 8 hour workday.

Patient can sit for approximately 8 hours out of an 8 hour day.

B. If your patient should alternate sitting/standing, please indicate how often that is needed:

It is my best estimate that the claimant should change positions approximately every 30 minutes/hours (cross off one).

C. If standing/walking is impacted by claimant's condition, indicate how many hours the patient can stand/walk out of an 8 hour workday.

Patient can stand/walk for approximately 2 hours out of an 8 hour day.

D. Please give your opinion as to the amount of pounds that the patient can safely lift without causing excess pain or worsening the condition, in a job requiring lifting on a daily basis five days per week.

	Should not at all	Occasional up to 1/3 of the day	Frequent up to 2/3 of the day
a. 0-5 pounds	()	(<u>5</u>)	()
b. 5-10 pounds	()	(<u>5</u>)	()
c. over 10 pounds	(<u>5</u>)	()	()

Oct 08 2020 10:14AM Guthrie 5708872327

page 4

OCT/03/2020/SAT 02:17 PM

FAX No.

P. 004

340616

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SEP/22/2020/TUE 09:40 AM

FAX No.

P. 005/005

6. If claimant has problems with his hands, arms, or wrists as a result of a medical condition which produces limitations to his ability to use his hands and arms, please indicate whether those limitations would be moderate or less, marked or severe.

Use as Follows:

Use less than
1/3 of each
working dayUse up to
1/3 of each
working dayUse more than
1/3 of every
working day

A. Right Hand: Fine Motor Activity

☒☐☐

B. Left Hand: Fine Motor Activity

☒☐☐

C. Right Arm & Hand: Reaching, Handling

☒☐☐

D. Left Arm & Hand: Reaching, Handling

☒☐☐

7. Based on history, your examinations, review of medical records of patient and objective, clinical and consistent subjective finding, what is the time period the answers herein represent?

6/10/2020 to 7/22/2020

Date:

10/7/20

Signature:

James Freeman, M.D.

Oct 01 2020 03:21PM Guthrie 5708872327

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Patient: Brown, Jennifer Lyn

#340616

Demographics



Jennifer Lyn Brown
 43 year old female
 10/26/1976
 Comm
 Pref:
 Works at Retired

14 MAIN ST LOT 429
 WELLSBURG NY 14894
 607-215-0584 (H)
 607-483-1886 (M)

Since Last Sayre Rheumatology Visit (8d Ago)

Sep 23



Office Visit with Rheumatology - Freeman, J
 Enteropathic arthritis (Primary Dx); Fibromyalgia

Problem List

36 items

- Severe obstructive sleep apnea
- Unspecified sinusitis (chronic)
- Plantar fascial fibromatosis
- HTN (hypertension), benign
- GERD (Gastroesophageal Reflux Disease)
- Rheumatoid arthritis (HCC)
- Hyperhidrosis disorder
- Obesity
- GAD (generalized anxiety disorder)
- Nontoxic multinodular goiter
- ADHD (attention deficit hyperactivity disorder)
- Environmental allergies
- Depression
- Fibromyalgia
- Status post bariatric surgery
- Tremor of left hand
- Benign head tremor
- Crohn's disease (HCC)
- Multiple benign nevi
- Cherry angioma
- Sun-damaged skin
- Neuritis
- Drug eruption
- Rash
- Long term current use of immunosuppressive drug
- Vitamin D deficiency
- Vitamin B12 deficiency
- Therapeutic drug monitoring
- Myopia of both eyes
- Bilateral dry eyes

Allergies

Bee Stings (Bee Sting) Swelling
 Oxycodone Hives
 Remicade (Infliximab) Rash
 Tape: Silk Or Adhesive Rash

Medications

Prior Authorizations

Outpatient Medications

ALPRAZolam (XANAX) 0.25 MG Oral Tab
 amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab
 Blood Glucose Monitor Software Does not apply Device
 buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR
 calcium carbonate (CALTRATE) 600 MG Oral Tab
 Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap
 cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution
 cyclobenzaprine (FLEXERIL) 10 MG Oral Tab
 EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector
 fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension
 foliC acid 1 MG Oral Tab
 gabapentin (NEURONTIN) 300 MG Oral Cap
 Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip
 Glucose Blood In Vitro Strip
 hepatitis A virus vaccine (VAQTA) 50 UNIT/ML Intramuscular Suspension

Oct 01 2020 03:22PM Guthrie 5708872327

page 8

Patient: Brown, Jennifer Lyn

#340616

Pain in joint, upper arm
 Impingement syndrome of left shoulder
 Eyelid twitch
 Enteropathic arthritis
 Allergic conjunctivitis of both eyes
 Chondral loose body of left knee joint

Survivorship

Active Problems

No active cancer problems

Resolved Problems

No resolved cancer problems

Immunizations/Injections

Hep A / Hep B Combined Vaccine (Adult)
 1/12/2017

Hepatitis A Vaccine-Adult 7/20/2020, 7/8/2016

Hepatitis B Vaccine Adult 8/12/2016, 7/12/2016,
 7/28/2000, ... (2 more)

Influenza (IM) Preservative Free 10/29/2019,
 10/3/2018, 10/11/2017, ... (5 more)

Influenza (IM) W/Pres 9/22/2016

Influenza Vaccine Whole 10/13/2015, 10/3/2011,
 10/28/2010

Lidocaine 1% (Not Billed) 2/16/2012

MMR VACCINE 1/28/2000, 1/26/1978

PNEUMOCOCCAL POLYSACCHARIDE
 VACCINE 7/8/2016

TDAP Vaccine 7/8/2016

Tuberculin Skin Test 7/11/2011, 7/27/2010

Vitamin B12 (1,000 mcg) 2/23/2017, 1/17/2017,
 12/16/2016, ... (12 more)

Relevant Results (Last 10 results in 10 years)

HYDROcodone-acetaminophen (NORCO)
 5-325 MG Oral Tab

✦ Insulin Syringe-Needle U-100 (ADVOCATE
 INSULIN SYRINGE) 31G X 5/16" 1 ML Does
 not apply Misc

Lancets Does not apply Misc

Levonorg-Eth Estrad Triphasic (TRIVORA,
 28,) 50-30/75-40/ 125-30 MCG Oral Tab

lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab

loratadine (CLARITIN, ALAVERT) 10 MG Oral
 Tab

ondansetron (ZOFTRAN ODT) 8 MG Oral
 TABLET DISPERSIBLE

pantoprazole (PROTONIX) 40 MG Oral Tab
 EC

predniSONE 5 MG Oral Tab EC

Probiotic Product (VSL#3) Oral Cap

Syringe/Needle, Disp, 25G X 1-1/2" 5 ML
 Does not apply Misc

Tofacitinib Citrate ER 22 MG Oral TABLET SR
 24 HR

venlafaxine (EFFEXOR XR) 150 MG Oral
 CAPSULE SR 24 HR

venlafaxine (EFFEXOR XR) 37.5 MG Oral
 CAPSULE SR 24 HR

Clinic-Administered Medications

saline (OCEAN) nasal spray 0.65 %

Recent Clinic Administered Med Administrations

The 5 most recent administrations since
 10/02/2019 are shown below each listed
 medication.

methyIPREDNISolone Acetate

Order	Dose	Date Given
methyIPREDNISolone acetate (DEPO-MEDROL) injection 80 MG/ML	80 mg	06/03/2020

methyIPREDNISolone acetate (DEPO-MEDROL) injection 80 MG/ML	80 mg	06/02/2020
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Specialty Comments

Edit
 Show all
 Report

No comments regarding your specialty



SOCIAL SECURITY ADMINISTRATION

Refer to: Jennifer Lyn Brown

Office of Appellate Operations
5107 Leesburg Pike
Falls Church, VA 22041-3255
Telephone: (877) 670-2722
Date: October 9, 2020, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Dear Ms. Brown:

On September 22nd, 2020, you asked the Appeals Council to review the Administrative Law Judge's decision. Our records show that you have appointed multiple representatives to represent you in your claim.

The current representative in your case is Peter Gorton since September 19th, 2020. There is also an Appointment of Representative form for Jonathan P. Foster Jr., dated October 17th, 2019.

We are writing to you because it is not clear whether:

- (1) the representatives are acting as co-representatives; or**
- (2) you intended to revoke the representation of any prior representative[s].**

We need you to send us a signed statement verifying your primary representative of record, or indicate if you are currently unrepresented.

Our address and FAX number are:

ADDRESS: Appeals Council
Office of Analytics, Review and Oversight
ATTN: Branch 7, Suite 1003
5107 Leesburg Pike
Falls Church, VA 22041-3255

FAX: (703)605-7331, Attn: Branch 7

Put your Social Security Number on your request.

If you send us anything by fax, please do not send duplicates by mail. That may delay processing your claim.

Jennifer Lyn Brown (132-58-2507)

Page 2 of 2

If You Have Any Questions

If you have any questions, you may call or write the Appeals Council. Our telephone number and address are as shown at the top of this letter. If you do call, please have this notice with you.

/s/ Takisha Samuels

Takisha Samuels
Lead Legal Assistant

Enclosure:
Self-addressed envelope

cc:
Peter Gorton
1500 E. Main St
PO Box 89
Endicott, NY 13761-0089

Jonathan P. Foster, Jr.
303 S. Keystone Ave
Sayre, PA 18840



SOCIAL SECURITY ADMINISTRATION

Refer to: Jennifer Lyn Brown

Office of Appellate Operations
5107 Leesburg Pike
Falls Church, VA 22041-3255
Telephone: (877) 670-2722
Date: September 29, 2020

Peter Gorton
1500 E. Main St
PO Box 89
Endicott, NY 13761-0089

Dear Mr. Gorton:

Re: Jennifer Lyn Brown, 14 Main St. Lot 429, Wellsburg, NY 14894

We have granted your request for more time before we act on your case.

You May Send More Information

You may send us a statement about the facts and the law in this case or additional evidence. We consider additional evidence that you show is new, material, and relates to the period on or before the date of the hearing decision. You must also show there is a reasonable probability that the additional evidence would change the outcome of the decision. You must show good cause for why you missed informing us about or submitting it earlier.

We Will Not Act For 25 Days

If you have more information, you must send it to us within 25 days of the date of this letter. We will not allow more time to send information except for very good reasons.

Our address and FAX number are:

ADDRESS: Appeals Council
ATTN: Branch 7, Suite 1003
5107 Leesburg Pike
Falls Church, VA 22041-3255

FAX: (877)310-0025 (must include barcode)

Put the claimant's Social Security Number on your request.

If you send us anything by fax, please do not send duplicates by mail. That may delay

Jennifer Lyn Brown

Page 2 of 2

processing your claim.

What Happens Next

If we do not hear from you within 25 days, we will assume that you do not want to send us more information. We will then proceed with our action based on the record we have.

This Letter is Only an Acknowledgement of Receipt

In sending this letter, we are only acknowledging that we received your request. We will make a separate decision to determine if you filed your appeal on time. If we determine that you filed your appeal on time, we will move forward with your appeal. If it appears that you filed your appeal late, we will send you a separate letter to give you a chance to explain why it was late or to prove that it was not late. You do not need to send us any information regarding whether you filed on time unless you hear from us separately on the issue.

If You Have Any Questions

If you have any questions, you may call or write the Appeals Council. Our telephone number and address are shown at the top of this letter. If you do call, please have this notice with you.

Takisha Samuels
Lead Legal Assistant

Enclosure(s):
Electronic Disability Claims Processing Insert
Barcode Sheets

cc:
Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our actions. Your client's disability claim file is being processed electronically.

We are forwarding a copy of the file and/or hearing recording to you on a compact disc (CD), as requested or your request for an extension of time to submit additional material (e.g., additional evidence and/or contentions) has been granted.

The preferred way to submit additional material to the electronic folder is by using one of the following three methods:

- **Send the evidence using the Electronic Records Express (ERE) website.**

In order to complete the destination section, please use the Site Code shown on the enclosed barcode or select Virginia from the State drop-down menu and then select the Falls Church – Appeals Council with the Branch Number as shown on the cover letter. For example, if the cover letter shows as part of the address, ATTN: Branch 01, you should select the following: VA-Falls Church-Appeals Council–PRB01 (X76). [Note: The Retirement and Survivors Insurance and Supplemental Security Income Branch is shown in the destination drop-down as VA-Falls Church-Appeals Council – RSI&SSI (X94).]

If you have not registered to use the ERE website, please contact your local hearing office.

- **Send the evidence to the contract scanner listed below. One of the enclosed barcodes must be the first page of each document. **DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.****

**SSA Appeals Council
P. O. Box 9060
London, KY 40742-9060**

- **Fax the evidence into the electronic folder using this fax number – (877)310-0025. Remember that one of the enclosed barcodes must be the first page for each document being faxed.**

You may also send the evidence by mail to the Branch Office listed on the cover letter, but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcodes pertain to your client's disability claim file only. Please keep the original barcode sheets for submitting all documents on this case. Barcodes may be used more than once when faxing evidence into the electronic file.

Claimant Name:	Jennifer Lyn Brown
Document Description:	Attorney/representative-supplied Evidence
Undated:	N
Sensitive:	N



RQID:0000000000000000283359464 SITE:Y84 DR:S
SSN:132582507 DOCTYPE:5032 RF:D CS:9d84



Office of Hearings Operations
5th Floor
300 S State St
Syracuse, NY 13202-9916

Date: August 07, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Notice of Decision – Unfavorable

I carefully reviewed the facts of your case and made the enclosed decision. Please read this notice and my decision.

If You Disagree With My Decision

If you disagree with my decision, you may file an appeal with the Appeals Council.

How To File An Appeal

To file an appeal you or your representative must ask in writing that the Appeals Council review my decision. The preferred method for filing your appeal is by using our secure online process available at <https://www.ssa.gov/benefits/disability/appeal.html>.

You may also use our Request for Review form (HA-520) or write a letter. The form is available at <https://www.ssa.gov/forms/ha-520.html>. Please write the Social Security number associated with this case on any appeal you file. You may call (800) 772-1213 with questions.

Please send your request to:

**Appeals Council
5107 Leesburg Pike
Falls Church, VA 22041-3255**

Time Limit To File An Appeal

You must file your written appeal **within 60 days** of the date you get this notice. The Appeals Council assumes you got this notice 5 days after the date of the notice unless you show you did not get it within the 5-day period.

Form HA-L76-OP2 (03-2010)

Suspect Social Security Fraud?
Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline
at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

The Appeals Council will dismiss a late request unless you show you had a good reason for not filing it on time.

What Else You May Send Us

You or your representative may send us a written statement about your case. You may also send us new evidence. You should send your written statement and any new evidence **with your appeal**. Sending your written statement and any new evidence with your appeal may help us review your case sooner.

How An Appeal Works

The Appeals Council will consider your entire case. It will consider all of my decision, even the parts with which you agree. Review can make any part of my decision more or less favorable or unfavorable to you. The rules the Appeals Council uses are in the Code of Federal Regulations, Title 20, Chapter III, Part 404 (Subpart J).

The Appeals Council may:

- Deny your appeal,
- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
- Dismiss your case.

The Appeals Council will send you a notice telling you what it decides to do. If the Appeals Council denies your appeal, my decision will become the final decision.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. If the Appeals Council reviews your case on its own, it will send you a notice within 60 days of the date of this notice.

When There Is No Appeals Council Review

If you do not appeal and the Appeals Council does not review my decision on its own, my decision will become final. A final decision can be changed only under special circumstances. You will not have the right to Federal court review.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with my decision and you file a new application instead of appealing, you might lose some benefits or not qualify for benefits at all. My decision could also be used to deny a new application for benefits if the facts and issues are the same. If you disagree with my decision, you should file an appeal within 60 days.

Jennifer Lyn Brown (132-58-2507)

Page 3 of 3

If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you. The telephone number of the local office that serves your area is (866) 964-1715. Its address is:

Social Security Admin
3345 Chambers Rd
Suite 19
Horseheads, NY 14845-0000

David Romeo
Administrative Law Judge

Enclosures:
Decision Rationale

cc: Jonathan P Foster, Jr Jr
The Foster Law Office
303 S. Keystone Ave
Sayre, PA 18840

**SOCIAL SECURITY ADMINISTRATION
Office of Hearings Operations**

DECISION

IN THE CASE OF

Jennifer Lyn Brown
(Claimant)

(Wage Earner)

CLAIM FOR

Period of Disability and Disability Insurance
Benefits

132-58-2507

(Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

On June 19, 2019, the claimant filed a Title II application for a period of disability and disability insurance benefits, alleging disability beginning June 19, 2019. The claim was denied initially on September 20, 2019, and upon reconsideration on January 22, 2020. Thereafter, the claimant filed a written request for hearing received on February 26, 2020 (20 CFR 404.929 *et seq.*). On July 22, 2020, the undersigned held a telephone hearing (20 CFR 404.936(c) / 416.1436(c)) due to the extraordinary circumstance presented by the Coronavirus (COVID-19) Pandemic. All participants attended the hearing by telephone, including the claimant, the claimant's attorney, Jonathan P Foster, Jr, and Zachary Fosberg, an impartial vocational expert. The claimant and the participating parties consented to a telephonic hearing.

The claimant submitted or informed the Administrative Law Judge about all written evidence at least five business days before the date of the claimant's scheduled hearing (20 CFR 404.935(a)).

ISSUES

The issue is whether the claimant is disabled under sections 216(i) and 223(d) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

There is an additional issue whether the insured status requirements of sections 216(i) and 223 of the Social Security Act are met. The claimant's earnings record shows that the claimant has acquired sufficient quarters of coverage to remain insured through December 31, 2024. Thus, the claimant must establish disability on or before that date in order to be entitled to a period of disability and disability insurance benefits.

After careful consideration of all the evidence, the undersigned concludes the claimant has not been under a disability within the meaning of the Social Security Act from June 19, 2019, through the date of this decision.

APPLICABLE LAW

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 404.1520(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 404.1520(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. “Substantial work activity” is work activity that involves doing significant physical or mental activities (20 CFR 404.1572(a)). “Gainful work activity” is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 404.1572(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that she has demonstrated the ability to engage in SGA (20 CFR 404.1574 and 404.1575). If an individual engages in SGA, she is not disabled regardless of how severe her physical or mental impairments are and regardless of her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is “severe” or a combination of impairments that is “severe” (20 CFR 404.1520(c)). An impairment or combination of impairments is “severe” within the meaning of the regulations if it significantly limits an individual’s ability to perform basic work activities. An impairment or combination of impairments is “not severe” when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual’s ability to work (20 CFR 404.1522, Social Security Rulings (SSRs) 85-28 and 16-3p). If the claimant does not have a severe medically determinable impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant’s impairment or combination of impairments is of a severity to meet or medically equal the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, and 404.1526). If the claimant’s impairment or combination of impairments is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 404.1509), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant’s residual functional capacity (20 CFR 404.1520(e)). An individual’s residual functional capacity is her ability to do physical and mental work activities on a sustained basis despite limitations from her impairments. In making this finding, the undersigned must consider all of the claimant’s impairments, including impairments that are not severe (20 CFR 404.1520(e) and 404.1545; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of her past relevant work (20 CFR 404.1520(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 404.1560(b) and 404.1565). If the claimant has the residual functional capacity to do her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g)), the undersigned must determine whether the claimant is able to do any other work considering her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, she is not disabled. If the claimant is not able to do other work and meets the duration requirement, she is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 404.1512 and 404.1560(c)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

- 1. The claimant meets the insured status requirements of the Social Security Act through December 31, 2024.**
- 2. The claimant has not engaged in substantial gainful activity since June 19, 2019, the alleged onset date (20 CFR 404.1571 *et seq.*).**

The claimant worked after the alleged disability onset date but this work activity did not rise to the level of substantial gainful activity. The record indicates that the claimant earned \$499 in the 3rd quarter of 2019, which is below the level of substantial gainful activity (Exhibit B6D, pg. 1). Accordingly, the undersigned will proceed to the next step in the sequential evaluation.

- 3. The claimant has the following severe impairments: obstructive sleep apnea, morbid obesity, rheumatoid arthritis, bilateral plantar fascial fibromatosis, Crohn's disease, left shoulder impingement syndrome, enteropathic arthritis, fibromyalgia, right shoulder bursitis, and generalized anxiety disorder (20 CFR 404.1520(c)).**

The above medically determinable impairments significantly limit the ability to perform basic work activities as required by SSR 85-28.

By contrast, there is insufficient evidence in the medical record that the claimant's history of ADHD has more than a *de minimis* effect on her to perform physical or work activities. As such, it constitutes a non-severe impairment in accordance with the definitions set forth in 20 CFR 404.1520 and 416.920. Indeed, there is little evidence of sustained treatment for this impairment during the period at issue. Additionally, as discussed in further detail below, the claimant has had largely unremarkable mental status examinations. Moreover, a consultative examiner indicated that she showed average intellectual functioning and only mild deficits in her attention, concentration, and memory skills (Exhibit B7F).

In addition, despite complaints of memory loss and right elbow and left knee pain, these do not constitute medically determinable impairments under relevant Social Security regulations. X-ray examinations of the right elbow and left knee performed in February 2019 and May 2020 were unremarkable (Exhibit B3F, pg. 124; B14F, pg. 63).

4. The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526).

As noted more fully below, despite the claimant's history of a bilateral shoulder impairment and bilateral plantar fasciitis, she does not meet or equal listing 1.02 as she has failed to show evidence of one of the following:

"Major dysfunction of a joint(s) (due to any cause): characterized by a gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;

OR

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.

Additionally, notwithstanding the claimant's history of rheumatoid and enteropathic arthritis, she has failed to show evidence of the following as required under listing 11.09:

A. Persistent inflammation or persistent deformity of:

1. One or more major peripheral weight-bearing joints resulting in the inability to ambulate effectively (as defined in 14.00C6); or

2. One or more major peripheral joints in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in 14.00C7).

OR

B. Inflammation or deformity in one or more major peripheral joints with:

1. Involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

OR

C. Ankylosing spondylitis or other spondyloarthropathies, with:

1. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or

2. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity.

OR

D. Repeated manifestations of inflammatory arthritis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

The severity of the claimant's mental impairments, considered singly and in combination, do not meet or medically equal the criteria of listing 12.06. In making this finding, the undersigned has considered whether the "paragraph B" criteria are satisfied. To satisfy the "paragraph B" criteria, the mental impairments must result in one extreme limitation or two marked limitations in a broad area of functioning. An extreme limitation is the inability to function independently,

appropriately, or effectively, and on a sustained basis. A marked limitation is a seriously limited ability to function independently, appropriately, or effectively, and on a sustained basis.

In understanding, remembering or applying information, the claimant has a mild limitation. The record confirms that the claimant has a history of anxiety and has reported problems with her memory and concentration. A consultative examiner indicated that the claimant showed mildly impaired attention, concentration, and memory skills. However, the claimant has had unremarkable mental status examinations. In addition, while the undersigned has accounted for the claimant's subjective complaints and determined that she has mild limitations in this domain of functioning, two DDS medical consultants opined that she has no limitations in her ability to understand, remember, or apply information (Exhibit B2A; B4A; B7F; B2F, pg. 13; B11F, pg. 39).

In interacting with others, the claimant has no limitation. Despite a history of anxiety, the claimant reported that she has supportive family members with whom she spends time and that she keeps in touch with friends. In addition, in her consultative examination, the claimant communicated in clear and fluent speech, maintained appropriate eye contact, and appeared well groomed. Furthermore, two DDS medical consultants opined that the claimant has no limitations in this domain of functioning (Id.).

With regard to concentrating, persisting or maintaining pace, the claimant has a moderate limitation. In various treatment notes, the claimant has reported experiencing anxiety. She also testified that she experiences memory and concentration problems and brain fog. In her consultative examination, however, the claimant showed only mildly impaired attention, concentration, and memory skills. In addition, the consultative examiner indicated that the claimant showed good insight and judgment and average intellectual functioning. Moreover, the claimant has had unremarkable mental status examinations. More recent treatment notes in May 2020 also indicate that the claimant's anxiety is under good control. Furthermore, there is no indication that the claimant has required psychiatric hospitalization throughout the period at issue (Id.; B13F, pg. 38).

As for adapting or managing oneself, the claimant has experienced a mild limitation. The claimant has reported having difficulty performing various day-to-day activities such as cleaning and maintaining her hygiene. However, she attributed her difficulties primarily to her physical rather than mental impairments. In addition, the claimant's boyfriend indicated that the claimant can count change, pay bills, cook, and visit with her mother. Furthermore, two DDS medical consultant opined that the claimant has no more than mild limitations in this domain of functioning (Exhibit B5E; B7F; B2F, pg. 13; B11F, pg. 39).

Because the claimant's mental impairments do not cause at least two "marked" limitations or one "extreme" limitation, the "paragraph B" criteria are not satisfied.

The undersigned has also considered whether the "paragraph C" criteria are satisfied. In this case, the evidence fails to establish the presence of the "paragraph C" criteria.

Notably, the claimant has failed to demonstrate the following: a medically documented history of the existence of a serious and persistent mental health disorder over a period of at least 2 years, and evidence of both of the following:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

The limitations identified in the “paragraph B” criteria are not a residual functional capacity assessment but are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment of the areas of mental functioning. The following residual functional capacity assessment reflects the degree of limitation the undersigned has found in the “paragraph B” mental function analysis.

5. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) except that the claimant can engage in occasional pushing, pulling, and overhead reaching with either upper extremity, and frequent reaching in all other planes. The claimant can occasionally operate foot controls, occasionally balance, stoop, kneel, crouch, crawl, and climb ramps and stairs. The claimant can never climb ladders, ropes, or scaffolds. She can frequently handle, finger, and feel with both upper extremities. She requires ready access to a restroom, but the need to use the restroom can be accommodated by the 15-minute morning and afternoon breaks and a 30-minute lunch period. The claimant would need an option to stand for 5 minutes after every 20 minutes of sitting; she can remain on-task while standing. Furthermore, the claimant cannot tolerate high-volume output, very short deadlines, or high levels of precision.

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 404.1529 and SSR 16-3p. The undersigned also considered the medical opinion(s) and prior administrative medical finding(s) in accordance with the requirements of 20 CFR 404.1520c.

In considering the claimant’s symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical or laboratory diagnostic techniques--that could reasonably be expected to produce the claimant’s pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant’s pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant’s symptoms to determine

the extent to which they limit the claimant's work-related activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must consider other evidence in the record to determine if the claimant's symptoms limit the ability to do work-related activities.

The claimant is a 43-year-old female with at least a high school level education. She alleges that she suffers from Crohn's disease, fibromyalgia, rheumatoid arthritis, plantar fasciitis, obesity, obstructive sleep apnea, a bilateral shoulder impairment, and anxiety. The claimant testified that she experiences diffuse body pain, including in the hands, feet, knees, and wrists. She notes that she is unable to sit, stand, or walk for extended periods, and is precluded from lifting and carrying heavy weight. In addition, she states that she experiences memory loss, difficulty concentrating, sleep disturbances, and spends a significant portion of her day in the bathroom or lying down. The claimant testified that she spends 80% of an 8-hour day in the bathroom. She also states that she experiences depressive thoughts, episodes of anxiety, and has difficulty dealing with stress. Furthermore, the claimant testified that she experiences side effects from her medications, including brain fog, nausea, and diarrhea. Based on her overall condition, the claimant alleges that she is unable to sustain work on a full-time basis.

After careful consideration of the evidence, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

A review the medical record indicates that although the claimant has received treatment for physical and mental impairments, her overall condition is not of a disabling character. In March and April 2019, the claimant underwent sleep studies, which revealed evidence of mild obstructive sleep apnea (B3F, pg. 94). Despite complaints of daytime sleepiness and difficulty falling and staying asleep, the claimant indicated that she had not been using a CPAP machine (Id. at 79). However, the sleep study indicated that the claimant showed a good response to CPAP (Id. at 94).

The claimant has also been diagnosed with left-sided impingement shoulder and AC arthritis. Due to the failure of conservative treatment modalities, in June 2019 she underwent arthroscopic surgery under the care of Dr. Joseph Choi, M.D. (Exhibit B2F, pg. 21). In a post-operative evaluations two week later, the claimant stated that her pain was under good control with medication, that she had discontinued using a sling, and had begun physical therapy exercises. She also denied experiencing symptoms of neuropathy and, upon examination, showed intact sensation, no evidence of infection, and normal radial pulses (Id. at 14). Additionally, subsequent physical therapy notes dated October 2019 indicate that the claimant had an unremarkable physical evaluation and showed improved tolerance for carrying groceries and engaging in overhead lifting activities. The claimant also stated that she was experiencing only minimal pain at night and was able to walk her dogs (Exhibit B11F, pg. 9).

The claimant also has a history of Crohn's disease. Despite complaints of abdominal pain, an MRI of the pelvis performed in June 2019 showed no evidence of active enteritis, stricture, fistulization, or abscesses (Exhibit B3F, pg. 127). Additionally, apart from erythematous mucosa in the antrum, colonoscopy and upper endoscopic studies performed that month were also unremarkable (Id. at 133-135). Dr. Michael Georgeston, M.D., did note that a follow-up colonoscopy performed in January 2020 revealed Crohn's disease of the small intestine without complications, as well as first-degree hemorrhoids and an ulcer of the intestine (Exhibit B14F, pg. 49). Notwithstanding these findings as well as occasional complaints of abdominal pain, multiple evaluations during the period issue indicate that the claimant's Crohn's disease was well-controlled, including evaluations in July, 2019, and December 2019 (Exhibit B5F, pg. 31; B11F, pg. 17; B12F, pg. 23). Additionally, in a more recent assessment dated May 2020, it was noted that the claimant's Crohn's disease was of a mild nature (Exhibit B13F, pg. 42). Taken cumulatively, these findings are inconsistent with the claimant's testimony in which she alleged that she spends 80% of an 8-hour day in the bathroom, which is not corroborated by the treatment record. Nevertheless, the undersigned has indicated in the residual functional capacity assessment that the claimant should have ready access to a restroom.

The claimant has also received treatment for fibromyalgia and rheumatoid arthritis. In a July 2019 assessment, the claimant stated that she was experiencing pain in the hips and knees. However, laboratory testing revealed only a slightly positive rheumatoid arthritis factor. In addition, the claimant denied experiencing any swelling (Exhibit B5F, pg. 31). Moreover, despite diagnosing the claimant with enteropathic arthritis, Dr. James Freeman, M.D., indicated that the claimant showed a normal range of motion of the joints, showed no evidence of edema or tenderness, and otherwise demonstrated normal cardiovascular and respiratory functioning. He did, however, note that the claimant had a body mass index of approximately 39, consistent with a diagnosis of obesity (Id. at 35). Pursuant to SSR 02-1P, the undersigned has taken the claimant's obesity into consideration in fashioning her residual functional capacity.

Despite complaints of pain in the hands and fingers in the right hand, an x-ray examination of the right hand performed in August 2018 was unremarkable (Exhibit B8F, pg. 5). Follow-up laboratory testing performed in December 2019 did, however, confirm that the claimant had a positive rheumatoid factor. The claimant reported experiencing bilateral wrist pain (Exhibit BF12, pg. 22). In a physical evaluation that month, the claimant showed widespread trigger point tenderness (Id. at 27). However, she continued to show a normal range of motion of the joints and was negative for signs of swelling (Id.). Moreover, the residual functional capacity above accounts for the claimant's subjective complaints by limiting her to sedentary work that involves no more than frequent handling, fingering, and feeling bilaterally.

The claimant has also reported experiencing right shoulder pain. However, an x-ray examination of the right shoulder performed in May 2020 was unremarkable (Exhibit B14F, pg. 64). In a follow-up assessment dated June 2020, the claimant had a positive impingement sign and was diagnosed with bursitis; however, she showed a normal range of motion of the shoulder, intact strength and sensation, and a negative drop arm test (Exhibit B13F, pg. 25). While the claimant underwent an injection procedure that month, there is no indication that she has undergone surgical intervention on the right shoulder throughout the period at issue (Id. at 26). However, to

account for the claimant's bilateral shoulder impairment, the undersigned has included reaching limitations in the residual functional capacity assessment above.

The record indicates that the claimant also has a history of bilateral plantar fascial fibromatosis (Exhibit B3F, pg. 16). The claimant reported experiencing pain in the feet and stiffness in the ankles for which she underwent physical therapy in 2018 (Id. at 20). While the undersigned has taken this impairment into consideration, there is little evidence of treatment for plantar fasciitis from the claimant's alleged onset date through the present. In addition, an x-ray examination of the left foot was seen to be normal (Exhibit B3F, pg. 116). Moreover, in a more recent evaluation dated June 2020, the claimant showed normal sensation in the foot and ambulated with a normal, unassisted gait (Exhibit B13F, pg. 14). Nevertheless, the claimant's subjective complaints of pain have been accommodated by the sedentary residual functional capacity above.

Although the record indicates that the claimant's impairments are primarily physical, she has also received treatment for anxiety. In a June 2019 report, the claimant stated that she had been experiencing increased anxiety over the past few months. Upon examination, although it was noted that the claimant showed an anxious mood, she communicated in normal speech, showed normal psychomotor behavior, demonstrated normal judgment and thought content, and denied experiencing suicidal or homicidal ideations. In addition, despite the claimant's testimony that she experiences memory and concentration problems, she showed normal cognition and memory (Exhibit B2F, pg. 13; see also B3F, pg. 125, which indicates that an April 2019 CT study of the head was normal).

Similarly, in an August 2019 assessment, the claimant showed a normal mood and affect and normal judgment (Exhibit B11F, pg. 39). In a more recent evaluation dated May 2020, it was noted that the claimant's anxiety was well-controlled (Exhibit B13F, pg. 38). It is also noteworthy that there is no indication that the claimant has engaged in acts of self-harm, required psychiatric hospitalization, or experienced episodes of decompensation throughout the period at issue. Notwithstanding the claimant's minimal psychiatric treatment, the undersigned has accounted for the claimant's history of anxiety by noting that she cannot tolerate high-volume output, very short deadlines, or work that requires a high level of precision.

The claimant's boyfriend has also submitted a Third-Party Function report dated July 2019. He indicated, *inter alia*, that the claimant has difficulty lifting, standing, walking, using her hands, and has problems with her memory and concentration. He did, however, note that the claimant can prepare meals, do online shopping, visit her mother, and pay bills and count change (Exhibit B5E). The claimant also testified that she can drive for short distances. Although the claimant's boyfriend did not provide an opinion *per se*, the findings contained in this report have been considered in formulating the claimant's residual functional capacity.

With regard to opinion evidence, in October 2019 the claimant underwent a physical consultative examination under the care of Dr. Gilbert Jenouri, M.D. Upon examination, Dr. Jenouri stated that although the claimant was unable to fully squat, she ambulated with a normal gait, did not require an assistive device, and was able to rise from a chair without difficulty. In addition, the claimant showed range of motion deficits of the spine, hips, and knees, trigger points in the shoulders, knees, and lumbar region, and slightly diminished strength in the left hand. However,

she showed a full range of motion of the elbows, forearms, wrists, and ankles, full muscle strength in the upper and lower extremities, and no sensory deficits or signs of muscle atrophy. Based on his assessment, Dr. Jenouri opined that the claimant has a mild restriction standing and walking for long periods, and bending, lifting, carrying, and engaging in stair climbing (Exhibit B8F). The undersigned finds this opinion somewhat persuasive. Dr. Jenouri's opinion is based on a thorough in-person examination of the claimant and is supported by clinical findings elicited in the course of his examination. However, his opinion overestimates the claimant's capacity to stand and walk during the workday in light of the medical record as a whole and the combined effect of the claimant's impairments.

Following a review the medical record in September 2019, Dr. J. Koenig, M.D., a DDS medical consultant, opined that the claimant can lift and carry 10 pounds frequently and 20 pounds occasionally, and can sit, stand, and walk 6 hours in an 8-hour day. He also noted that the claimant can frequently perform most postural activities and frequently handle and finger with the left hand (Exhibit 2A). Upon reconsideration in December 2019, Dr. S. Naroditsky, M.D., also opined that the claimant can lift and carry 10 pounds frequently and 20 pounds occasionally, and sit, stand, and walk 6 hours in an 8-hour day. He also noted that the claimant should avoid concentrated exposure to hazards such as machinery and heights (Exhibit B4A). The undersigned find these opinions partially persuasive. Although the opinions of Dr. Koenig and Naroditsky are based on a knowledge of Social Security's disability program, they did not have an opportunity to personally examine the claimant or review more recent medical evidence. In addition, their opinions overestimates the degree to which the claimant can stand and walk during the workday as well as perform postural activities, particularly in light of the combined effect of the claimant's multiple impairments.

With regard to the claimant's psychiatric limitations, in August 2019 she also underwent a psychiatric consultative examination under the care of Dr. Amanda Slowik, PsyD. Upon examination, the claimant communicated in clear and fluent speech, showed a coherent and goal-directed thought process and, despite an anxious affect, showed no evidence of hallucinations, delusions, or paranoia. Following a set of mental exercises, Dr. Slowik stated that the claimant showed mildly impaired attention, concentration, and memory skills. However, she indicated that the claimant showed average intellectual functioning, and good insight and judgment. The claimant also reported that she has supportive family members with whom she spends time and that she keeps in touch with family and friends. Furthermore, although the claimant stated that she has difficulty performing various activities of daily living such as brushing her hair, cleaning, and shopping, she attributed her limitations primarily to her physical rather than mental impairments (Exhibit B7F).

Based on her assessment, Dr. Slowik opined that the claimant has moderate limitations interacting with supervisors, co-workers, and the public, sustaining an ordinary routine, and regulating her emotions. In addition, she indicated the claimant has mild limitations understanding, remembering, or applying complex directions and sustaining concentration. However, Dr. Slowik stated the claimant has no limitations remembering or applying simple directions, taking awareness of normal hazards, and maintaining her personal hygiene (Exhibit B7F). The undersigned finds Dr. Slowik's opinion somewhat persuasive. Her opinion is based on a specialized understanding of psychiatric disorders and an in-person examination of the

claimant. However, while Dr. Slowik's opinion is generally consistent with the record as a whole, there is insufficient evidence to support a finding that the claimant is moderately limited in her ability to sustain a routine, interact with others, or regulate her emotions. On the contrary, the record indicates that the claimant has received only mild and intermittent psychiatric treatment and that her condition is generally well-controlled.

Finally, following a review of the medical record in September 2019, DDS medical consultant, Dr. M. Marks, PsyD, opined that the claimant has no limitations understanding, remembering, or applying information, or interacting with others, mild limitations maintaining concentration, persistence, and pace, and mild limitations adapting or managing herself (Exhibit B2A). This opinion was affirmed upon reconsideration by Dr. C. Walker, PhD, in December 2019 (Exhibit B4A). The undersigned finds these opinions persuasive. While Dr. Marks and Walker also did not examine the claimant or review more recent medical records, their opinion is consistent with the longitudinal treatment record and is based on a knowledge of Social Security disability program. These opinions do, however, overestimate the claimant's ability to maintain concentration, persistence, and pace in light of her documented symptoms and subjective complaints.

In sum, based upon the objective medical record, the above-mentioned opinions, and taking into account the claimant's subjective allegations, the undersigned finds that the claimant retains the capacity to perform sedentary work with the aforementioned nonexertional limitations. Ultimately, the exertional, postural, reaching, manipulative, and mental limitations set forth herein accommodate the claimant's subjective limitations and are supported by, and consistent with, the objective medical findings. No additional limitations are warranted.

6. The claimant is unable to perform any past relevant work (20 CFR 404.1565).

The claimant has past relevant work as an office manager. As required by SSR 82-62, this work was substantial gainful activity, was performed long enough for the claimant to achieve average performance, and was performed within the relevant period. However, pursuant to the Dictionary of Occupational Titles, a vocational expert testified that the demands of the claimant's past relevant work as actually and generally performed exceed her residual functional capacity (see DOT number 169.167-034, which indicates that this job is performed at the sedentary exertional level, but has an SVP 7). Accordingly, the claimant is unable to perform past relevant work as actually or generally performed.

7. The claimant was born on October 26, 1976 and was 42 years old, which is defined as a younger individual age 18-44, on the alleged disability onset date (20 CFR 404.1563).

8. The claimant has at least a high school education (20 CFR 404.1564).

9. Transferability of job skills is not material to the determination of disability because using the Medical-Vocational Rules as a framework supports a finding that the claimant is "not disabled," whether or not the claimant has transferable job skills (See SSR 82-41 and 20 CFR Part 404, Subpart P, Appendix 2).

10. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 404.1569 and 404.1569(a)).

In determining whether a successful adjustment to other work can be made, the undersigned must consider the claimant's residual functional capacity, age, education, and work experience in conjunction with the Medical-Vocational Guidelines, 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either "disabled" or "not disabled" depending upon the claimant's specific vocational profile (SSR 83-11). When the claimant cannot perform substantially all of the exertional demands of work at a given level of exertion and/or has nonexertional limitations, the medical-vocational rules are used as a framework for decisionmaking unless there is a rule that directs a conclusion of "disabled" without considering the additional exertional and/or nonexertional limitations (SSRs 83-12 and 83-14). If the claimant has solely nonexertional limitations, section 204.00 in the Medical-Vocational Guidelines provides a framework for decisionmaking (SSR 85-15).

If the claimant had the residual functional capacity to perform the full range of sedentary work, a finding of "not disabled" would be directed by Medical-Vocational Rule 201.28. However, the claimant's ability to perform all or substantially all of the requirements of this level of work has been impeded by additional limitations. To determine the extent to which these limitations erode the unskilled sedentary occupational base, the Administrative Law Judge asked the vocational expert whether jobs exist in the national economy for an individual with the claimant's age, education, work experience, and residual functional capacity. The vocational expert testified that given all of these factors the individual would be able to perform the requirements of representative occupations such as a telephone order clerk (DOT No. 209.567-014), inspector (DOT No. 669.687-014), and credit clerk (DOT No. 205.367-014). Each of these jobs involve sedentary work and have SVP of two. They exist in the national economy in the following numbers: 55,000 jobs (telephone order clerk), 13,000 jobs (inspector), and 45,000 jobs (credit clerk respectively).

Pursuant to SSR 00-4p, the undersigned has determined that the vocational expert's testimony is consistent with the information contained in the Dictionary of Occupational Titles.

Based on the testimony of the vocational expert, the undersigned concludes that, considering the claimant's age, education, work experience, and residual functional capacity, the claimant is capable of making a successful adjustment to other work that exists in significant numbers in the national economy. A finding of "not disabled" is therefore appropriate under the framework of the above-cited rule.

11. The claimant has not been under a disability, as defined in the Social Security Act, from June 19, 2019, through the date of this decision (20 CFR 404.1520(g)).

DECISION

Jennifer Lyn Brown (132-58-2507)

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Based on the application for a period of disability and disability insurance benefits filed on June 19, 2019, the claimant is not disabled under sections 216(i) and 223(d) of the Social Security Act.

/s/ *David Romeo*

David Romeo
Administrative Law Judge

August 07, 2020

Date

LIST OF EXHIBITS

Payment Documents/Decisions

Component	No.	Description	Received	Dates	Pages
X02	B1A	Order of Dismissal		2015-10-22	4
X02	B2A	Disability Determination Explanation Initial PRT by PhD; PRFC by MD		2019-09-18	13
X02	B3A	Disability Determination Transmittal Initial		2019-09-18	1
X02	B4A	Disability Determination Explanation Recon PRT by PhD; PRFC by MD		2019-12-17	14
X02	B5A	Disability Determination Transmittal Recon		2019-12-17	1

Jurisdictional Documents/Notices

Component	No.	Description	Received	Dates	Pages
X02	B1B	T2 Notice of Disapproved Claim		2019-09-20	6
X02	B2B	SSA-1696 - Claimant's Appointment of a Representative Jonathan Foster Jr		2019-10-17	5
X02	B3B	SSA-1693 - Fee Agreement for Representation before SSA Foster Jr/Foster Sr		2019-10-17	1
X02	B4B	Request for Reconsideration		2019-10-23	1
X02	B5B	T2 Disability Reconsideration Notice		2020-01-22	12
X02	B6B	Request for Hearing by ALJ		2020-02-26	2
X02	B7B	Request for Hearing Acknowledgement Letter		2020-03-05	15
X02	B8B	Outgoing ODAR Correspondence			2

X02	B9B	Waive Advance Notice of Hearing	2020-06-23	2
X02	B10B	Hearing Notice	2020-06-29	19
X02	B11B	Acknowledge Notice of Hearing	2020-06-30	2
X02	B12B	Waive Advance Notice of Hearing	2020-06-30	2

Non-Disability Development

Component	No.	Description	Received	Dates	Pages
X02	B1D	Application for Disability Insurance Benefits		2019-06-19	3
X02	B2D	Application for Disability Insurance Benefits		2019-06-20	2
X02	B3D	SEI/Wage Verification		2019-07-12	8
X02	B4D	Detailed Earnings Query		2020-05-13	4
X02	B5D	Summary Earnings Query		2020-05-13	1
X02	B6D	New Hire, Quarter Wage, Unemployment Query (NDNH)		2020-05-13	2
X02	B7D	Certified Earnings Records		2020-05-13	3

Disability Related Development

Component	No.	Description	Received	Source	Dates	Pages
X02	B1E	Disability Report - Adult		Claimant	to 2019-06-27	11
X02	B2E	Disability Report - Field Office		Claimant	to 2019-06-27	3
X02	B3E	Function Report - Adult		Claimant	to 2019-07-04	16
X02	B4E	Work History Report		Claimant	to 2019-07-04	10
X02	B5E	3rd Party Function Report - Adult		Jonathan Foote	to 2019-07-08	13
X02	B6E	DDS Disability Worksheet			2019-07-01 to 2019-09-20	9
X02	B7E	Disability Report - Field Office			to 2019-10-24	2

X02	B8E	Disability Report - Appeals	Jonanthan Foster Jr	to 2019-10-24	10
X02	B9E	Function Report - Adult	Claimant	to 2019-11-20	12
X02	B10E	Disability Report - Field Office		to 2020-02-27	2
X02	B11E	Disability Report - Appeals	Jonanthan Foster Jr	to 2020-02-27	10
X02	B12E	Exhibit List to Rep PH2E		to 2020-05-13	3
X02	B13E	Report of Contact	Oho	to 2020-06-16	1
X02	B14E	Report of Contact	Csu	to 2020-06-23	1
X02	B15E	Resume of Vocational Expert	Zachary Fosberg Crc	to 2020-07-01	1

Medical Records

Component	No.	Description	Received	Source	Dates	Pages
X02	B1F	Office Treatment Records		Michael Gillan Do	2018-01-22 to 2019-01-31	25
X02	B2F	HIT MER		Guthrie Health System	2018-06-25 to 2019-06-26	309
X02	B3F	Hospital Records		Robert Packer Hospital	2018-05-26 to 2019-06-26	139
X02	B4F	Medical Source - No MER Available		Thomas Mcdonald Md		2
X02	B5F	Office Treatment Records		James Freeman Md	2008-09-03 to 2019-07-20	58
X02	B6F	Medical Source - No MER Available		Preetika Sinh Md	to 2019-08-07	6
X02	B7F	CE Psychiatry		Amanda Slowik Psyd	to 2019-08-21	6
X02	B8F	CE Internal Medicine		Gilbert Jenouri Md	to 2019-08-21	7
X02	B9F	Unsuccessful Development Attempt to Secure Medical		Preentika Sinh Md	to 2019-08-28	4

X02	B10F	Request Administrative Information	J Koenig Md	to 2019-09-09	2
X02	B11F	HIT MER	Guthrie Health System #2		57
X02	B12F	Office Treatment Records	Guthrie Clinic Sayre	2019-09-13 to 2019-12-23	53
X02	B13F	Office Treatment Records	Guthrie Clinic Sayre	2020-01-17 to 2020-06-10	65
X02	B14F	Office Treatment Records	Robert Packer Hospital	2019-01-07 to 2020-06-23	76

**SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS OPERATIONS**

TRANSCRIPT

In the case of:

Jennifer Lyn Brown

Claimant

Claim for:

Period of Disability and
Disability Insurance Benefits

132-58-2507

Wage Earner
(Leave blank in SSI Claims, or if the name
is the same as above.)

Social Security Number

Hearing Held at:

Unknown location

(City, State)

July 22, 2020

(Month, Day, Year)

by:

David Romeo

(Administrative Law Judge)

APPEARANCES:

Jennifer Lyn Brown, Claimant
Jonathan P. Foster, Jr., Attorney for Claimant
Zachary T. Fosberg, Vocational Expert

INDEX OF TRANSCRIPT

In the Case of:

Account Number

Jennifer Lyn Brown

132-58-2507

Page Commencing

Testimony of Jennifer Lyn Brown

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Testimony of Zachary T. Fosberg

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(The following is a transcript of the telephonic hearing held before David Romeo, Administrative Law Judge, Office of Hearings Operations, Social Security Administration, on July 22, 2020, at an unknown location, in the case of Jennifer Lyn Brown, Social Security number 132-58-2507. The administrative law judge presided over the hearing via telephone due to the extraordinary circumstance presented by the Coronavirus Disease 2019 (COVID-19) pandemic. The claimant appeared and was represented by her attorney, Jonathan P. Foster, Jr. Also present was Zachary T. Fosberg, vocational expert.)

HR: This is the hearing in the case of Jennifer Brown, B-R-O-W-N. Social Security number 132-58-2507. The claimant filed an application for disability insurance benefits. The hearing is being held on July 22nd, 2020. The representative is Jonathan Foster, Jr. The vocational expert is Zachary Fosberg. The administrative law judge is David Romeo. The hearing reporter is Janet Livingston.

(The hearing commenced at 11:34 AM, on July 22, 2020.)

HR: On the record.

OPENING STATEMENT BY ADMINISTRATIVE LAW JUDGE:

ALJ: Good morning everyone. I'm Judge Romeo. I'm the administrative law judge. I was assigned to hear this case this morning, and this is the claim of Jennifer Lynn Brown, Social Security number 132-58-2507. The hearing's scheduled today, 7/22/20 out of the Syracuse, New York Hearing Office, but due to the coronavirus restrictions, all hearings are being conducted upon consent by telephone. The hearing involves a claim for Title 2 disability benefits that was denied on initial review and is now before me on a written request for hearing. The claimant is

present by telephone and represented by Jonathan Foster. Zachary Fosberg is present by telephone to testify as our vocational expert. And Janet Livingston is coordinating the conference call, operating the recording equipment, taking notes, and assisting me during the hearing. I had no prior knowledge of this case, and I'm not bound by any previous determination. Now, Counsel, may I have your consent, and your client's consent, to hold this morning's hearing by telephone and waive any objections?

ATTY: Yes, Your Honor, I provide my consent to have a hearing by telephone.

ALJ: Okay. And ma'am, you understand that and agree as well, Ms. Brown?

CLMT: Yes, yes, I --

ALJ: Oh --

CLMT: --also agree.

ALJ: Okay. I will remind the parties there can be no recording of the hearing, other than the official recording. Absent permission being given, requested and given, all participants must be sequestered to ensure the privacy of the claimant's personal information and the claimant may not rely on anyone else for her testimony, either in person or by text. I am appearing from my home office, and I am sequestered. Now Counsel, have you had a chance to review the record with your client?

ATTY: Yes I have, Your Honor.

ALJ: Do you have any objection to the documents in the

exhibit file?

ATTY: No objections, Your Honor.

ALJ: Exhibits B1A through B14F are admitted into evidence.

(Exhibits B1A through B14F, previously identified, were received into evidence, and made a part of the record thereof.)

ALJ: Is there anything outstanding at this time, Mr. Foster?

ATTY: No, Your Honor. The record is complete.

ALJ: And do you waive a formal reading of the issues?

ATTY: Yes, Your Honor, I will waive the reading.

ALJ: Okay. And Ms. Brown, this is a fact finding proceeding. It's informal. I'm gonna ask you some questions about your disability. If you don't understand any question, feel free to ask me to repeat it, or to rephrase it. There is some formality in that you'll be testifying under oath. The hearing's also being recorded, so you'll need to reply in a nice clear voice.

CLMT: Okay.

(The oath was administered.)

(The claimant, JENNIFER LYN BROWN, having been first duly sworn, testified as follows:)

EXAMINATION OF THE CLAIMANT BY THE ADMINISTRATIVE LAW JUDGE:

Q Okay. And Ms. Brown, would you please state your name and address for the record?

A Yes, it's Jennifer Lyn Brown. 14 Main Street, Lot 429, Wellsburg, New York 14894.

Q Thank you. And may we also have your Social Security number and your date of birth?

A Yes, it's 132-58-2507. My date of birth is October 26, 1976.

Q I can confirm that's consistent with the information we have on record. Do you live with anyone else at this address?

A Yes, I live with my boyfriend.

Q Okay, just the two of you?

A Yes.

Q And if you're not working, or it appears that you're not working now, how are you getting by financially?

A My boyfriend is taking care of me.

Q Does he work?

A No. He's on disability.

Q Do you receive any types of public assistance?

A Food stamps.

Q Do you have Medicaid?

A Yes, I have the essential plan, it [INAUDIBLE] --

Q Okay.

A -- Blue Cross and Blue Shield through state.

Q All right. Do you have a driver's license?

A Yes, I do.

Q Are you able to drive?

A Yes.

Q And is your driving limited at all by any of your impairments?

A Yes, I can't drive for long periods of time.

Q And when you say long periods of time, can you quantify that for us?

A Yeah, probably anything over, anything over 12 miles, I would say. Like I --

Q Okay.

A -- can go down 12 miles and 12 miles back, but anything longer than that's too hard to.

Q All right, and in an average week, how many times do you think you might drive?

A Probably once or twice. I only usually go for my appointments.

Q Do you have to drive your boyfriend anywhere?

A No.

Q Okay. We have that you had two years of college for your education. Does that sound right?

A That's correct.

ALJ: In your work history, and Counselor, past relevant work I have supervisor of office operations in a hospital. Does that sound correct?

CLMT: Correct, yes.

ALJ: And Counsel, do you agree?

ATTY: Yes, Your Honor.

ALJ: Okay. Mr. Fosberg, any questions on any of the specific aspects of that one job?

(The vocational expert, ZACHARY T. FOSBERG, having been first

duly sworn, testified as follows:)

VE: I don't believe so, Your Honor, not at this time.

ALJ: Okay, thank you.

BY THE ADMINISTRATIVE LAW JUDGE:

Q Now ma'am, we have your alleged onset date, June 19th, 2019, a little over a year ago. Since then have you worked anywhere at all?

A No, I have not.

Q Okay. And have you applied for any jobs?

A I have not, no.

Q And that's when you left the hospital, correct?

A It is, correct.

Q And what were the circumstances to leaving, with respect to leaving the hospital? What happened?

A I was having too much pain, extreme inflammation. I have pain in my hands, my wrists, I can't stand for long periods of time, I can't sit for long periods of time. I can't concentrate, I have short-term memory loss, my organization, everything, it was just going downhill. I have problems, anything, any kind of stress, brings on my inflammation even more, and plus I'm in the bathroom a lot because I have Crohn's, besides the rheumatoid arthritis. So I spend very long periods of time in the bathroom, and it takes away from my work.

Q So what happened with work?

A I put in my notice and left.

Q Okay.

A I wasn't, I wasn't let go. I had to leave. I just couldn't do it anymore.

Q Okay, because of your problems?

A Correct.

Q Since you stopped work, have you ever received any other types of benefits?

A No, I do not.

ALJ: Okay. And, all right, ma'am, I am going to turn the questioning over to your representative, and I might have some follow-ups. Thank you very much.

CLMT: Okay.

ALJ: Go ahead, Counselor.

ATTY: Thank you, Your Honor.

EXAMINATION OF THE CLAIMANT BY THE ATTORNEY:

Q Do you have any difficulty sleeping at all?

A Yes, I, I'm sleep deprived. I have a lot of, I can't sleep because of the pain.

Q And are you taking any medication to help with your sleep?

A I take, yes, I take quite a few medications. I'm on gabapentin, I take that at night time. I'm on a lot of anxiety and depression medication, the highest doses that they could possibly give me.

Q And, and in terms of the household chores are you, are

you able to do anything around the house?

A I am not. A lot of times, things just pile up. I hate to say that, but things just pile up and they don't get done, because my boyfriend, he's also disabled, so he's not able to do things either. So a lot of times just things sit there. A lot of times I [INAUDIBLE].

Q And what do you spend most of your day doing?

A A lot of times I, since I get up in the morning, I actually go right back out and lay right back down. So a lot of my days consist of laying down and sleeping, 'cause I'm so fatigued.

Q And, and about what percentage of a day would you say you spend laying down?

A Probably about 80 to 90 percent.

Q And how long would you be able to, to stand in an eight-hour workday?

A I cannot stand, even if I'm standing, like even if I try to stand, for example, out at the stove. For instance, last night I tried to make a dinner and I couldn't even stand there. I had to actually go and sit down for a few minutes and then get back up.

Q So how long do you think you could stand for, like, maybe a half-hour or more or less than that?

A Less than that.

Q Okay. [INAUDIBLE]

A I have inflammation in my feet.

Q Okay, and that's what I was gonna ask you. Where are you

experiencing pain when you're standing for a long period of time?

A My feet, my knees. I know it doesn't affect my standing, but my, I have really bad pain in my hands and my wrist. That's another thing I had problems with at work was typing. I couldn't type all the time.

Q And, do you have any difficulty sitting?

A Yeah, I can't sit for long periods of time, either. I constantly have to get up to also go to the bathroom, but also sitting bothers my hip joints, my lower back.

Q And how long do you think --

A I have problems with my back --

Q And, and how long do you think that you could sit in an eight-hour day?

A Probably half an hour, maybe? 'Cause I constantly have to get up, and then I sit back down, then I get back up again, or else I have to lay down.

Q And does laying down relieve the pain at all?

A It does, but it's just, I toss and turn.

Q And then, what about walking? Do you have any difficulty walking?

A Yes. I have a lot of difficulty walking, actually. I, I have a relative that lives close by to me, and even if I try to walk to their house, I have difficulty. In fact, yesterday, I had to start using a cane to do it.

Q [INAUDIBLE]. Okay. And how far can you walk?

A I'm not really good with distance. I'm trying to think.

Q And I guess if we use like a in-town typical block, how many blocks could you walk?

A I couldn't walk a whole block. No, not even a whole block. I could probably make maybe half a block. I don't even think I could, walk half a block, actually.

Q Okay. And, and earlier you mentioned that you have some concentration problems, can you elaborate on that?

A Yeah, I have short-term memory loss. I'm actually seeing a doctor for that, because I having problems remembering things a lot. They think it's coming from my medication. I have brain fog a lot, so I, I just lose my concentration. You can tell me something and then ask me again maybe in a half an hour, and I can't remember. I can't remember things, like I have to constantly make notes all the time. For instance, my mom will tell me something, and she'll turn around and ask me later, and I'll be like you told me that? I have no recollection.

Q Okay.

A But I can, I can remember things from long ago.

Q Okay. And were, were you having any of those memory problems when you were last working at the Guthrie Clinic?

A Oh yes. My organization, I used to be a very organized person, and I lost all my organization skills. In fact, my manager, that was one of the things that she was on me about, was my organization was gone. I couldn't remember things, I couldn't

remember things that I had to get done. I couldn't complete my task.

Q And, and are you still suffering from the Crohn's disease?

A I am, yes. I'm in the bathroom a lot. I either have diarrhea or I have constipation. It fluctuates, so I spend long periods of time in the bathroom. In fact, I just saw a doctor on Monday again, my regular GI doctor, and he was concerned. He's going to try another medication for me, and he sent me for a CT scan and lab work.

Q And --

A I have --

Q And on average, how many times do you have to use the bathroom in a day?

A Oh boy, it can be any given, any given moment. Multiple times. I don't even, I get to the point where I don't even count anymore because I'm in the bathroom so much. And, and that's another thing. If I do have to go somewhere, I have to go somewhere where there is a restroom and it's close by. And, you know, I have to have access to a bathroom right away, but that's another problem that takes away from, it was taking away from my work all the time. I was constantly in there. People were looking for me, they couldn't find me, 'cause I was in the bathroom all the time.

Q And, you know, if you, if you had to use the bathroom in

an eight-hour time period, how many bathroom breaks do you think you would need?

A It could be anywhere from 20, 25. I mean, I could go to the bathroom constantly. A lot of, I don't want to be gross or anything, but a lot of my food runs right through me. And actually sometimes even my medication runs right through me. And I, and I, I can, you know, tell that it runs right through me.

Q So out of an eight-hour day, how, how much of the day would you be spending in the bathroom?

A Probably 80 percent.

Q Okay. And how is your arthritis affecting you?

A It's really affecting me bad. My, my arthritis is really bad right now. My hands, my joints, my fingers. My hands, I, I can, like, when I first wake up in the morning, soon as I do wake up, my hands are all curled up and I sometimes had to pry them open. It affects me because obviously I don't sleep at night. So, I'm tired all the time, plus all the medication that I'm on, all the side effects from that, makes me just so fatigued. Nausea.

Q And, how is your depression and anxiety?

A It's not good.

Q [INAUDIBLE]

A Yeah, I'm, even though I'm on the highest doses of medication, I mean, Dr., my primary doctor actually gave me another anxiety medicine just to take in case I need it. And I have another one for night time, for trying to sleep. He thinks it'll

help me sleep at night, but it doesn't. It doesn't help me. And of course, being out of work, being home, my anxiety bothers me a lot because, you know, I don't have an income coming in. I worked for 19 years and, I just didn't, you know, up and leave because, you know, for, for the fun of it. I'm, I definitely have things wrong with me, because I've always been a hard worker over the years and now all of the sudden I can't do what I used to do anymore, and. And I, I think of other positions that I could do, that I could think I could do, but I can't do them, because just even the stress from everything, the stress at work, anywhere that I've worked in the past, and any jobs that I've done in the past, just thinking of those, that stressed. It makes my inflammation just flare right up, plus with my Crohn's. Any inflammation bothers my arthritis and my Crohn's. Any stress.

Q And do you have any side effects from any of the medications you're taking?

A Yeah, I do. Fatigue, the brain fog, nausea, sometimes diarrhea actually comes from that too, besides the Crohn's. The memory loss. I also have problems with my neck. I have a lot of joint pain in my neck and I have to get injections for that. They usually give me four to six injections right underneath the hairline on my left side of my neck.

Q And, do you engage in any social activities?

A I do not, actually. Especially since things have gotten worse. I don't really have friends outside of the home. I don't

go anywheres. I, I don't attend church. Mostly everything is just, I'm mostly a homebody. I don't do anything.

Q And have you suffered any weight loss at all as a result of your symptoms?

A Weight loss?

Q Yes.

A No, I've actually, it's off and on. My weight fluctuates. I do, I lose weight because of the Crohn's, but then I turned around and gained the weight because of stress. I actually, a while I had a gastric sleeve surgery in 2014, but it actually, I, it helped at the time, but now it's, it's not working the way it should have worked.

Q Okay. And do you suffer from severe fatigue?

A Severe what? Fatigue?

Q Fatigue.

A Yes.

Q Are you, are you tired all the time or [INAUDIBLE] --

A I'm tired -- no, I'm tired all the time. I'm always dragging, it's an awful feeling. I'm just constantly tired, no matter what. I have to push myself to function every day.

Q Okay. And would you still be working if you were physically and mental, mentally capable of working?

A Oh yes, I mean, I worked for, like I said, I worked for 19 years, and I've always, and I worked before that. I've worked ever since I was able to. And then I, I went to school for

associate, like I said, I have associates degree in science for medical secretarial work. So I've always worked, but because of what I'm going through, I just can't work anymore. I can't do it, and I would have never just left on a, you know, on a whim because of something. I mean, I definitely can't.

Q And is there anything else you wanted to tell the judge about limitations affecting your ability to work?

A Just that I, I mean, I'm always gonna have an autoimmune disease, both of them, rheumatoid arthritis and Crohn's, they're both autoimmune diseases. They're never gonna go away, they're in my system, unfortunately. I've been handed them, and I have to live with them the rest of my life. And they do affect me tremendously. I run into bathroom all the time and, there's extreme fatigue and everything, and the pain in my joints, and the stress. I just, I, I'm just gonna have to, I always gonna have it. It's never gonna go away. Yeah, I might have a good day, but my bad days outweigh my good days.

ATTY: I have no further questions, Your Honor.

ALJ: Okay, thank you. I don't have any other questions for Ms. Brown.

EXAMINATION OF VOCATIONAL EXPERT BY ADMINISTRATIVE LAW JUDGE:

Q Mr. Fosberg, would you please state your full name for the record?

A Yes, Zachary Fosberg, vocational consultant.

Q And is the résumé in the file a true description of your

professional qualifications?

A Yes, Your Honor.

ALJ: Mr. Foster, will you stipulate to Mr. Fosberg's qualifications?

ATTY: Yes, Your Honor.

ALJ: Okay.

BY THE ADMINISTRATIVE LAW JUDGE:

Q And Mr. Fosberg, can you give an impartial and neutral opinion in this case even though the Social Security Administration is paying your fee?

A Yes, I can.

Q And did you discuss your testimony with me or the claimant prior to the hearing?

A No, I have not.

Q And have you read and listened to the claimant's testimony regarding work history?

A Yes, I have.

Q And would you please describe her past work?

A Yes, the claimant's past work would be classified as one position, as an office manager, DOT code 169.167-034. This is considered skilled, SVP 7, and classified in the DOT at the sedentary exertion level.

Q Thank you. I'd like you to assume a hypothetical individual of the claimant's age and education, with the past job you described. Further assume the individual is limited to a

sedentary exertional level with the following additional limitations. Occasional pushing and pulling, and overhead reaching with either upper extremity. Frequent reaching in all other planes. Occasional operation of foot controls, occasional balance, stoop, kneel, crouch, crawl, climb ramps, and the stairs. Never climb ropes, ladders, or scaffolds. Frequent handle, finger, and feel with both upper extremities. Requires ready access to a restroom, but the need to use the restroom can be accommodated by the 15-minute morning and afternoon breaks and the 30-minute lunch period. Would need an option to stand for five minutes after every 20 minutes of sitting, but could remain on task while standing. And cannot tolerate high-volume output, very short deadlines, or high levels of precision. Can this hypothetical individual perform past work?

A Your Honor, would you be able just to repeat the last limitation?

Q The last limitation is, cannot tolerate high-volume output, very short deadlines or high levels of precision.

A In my vocational opinion, Your Honor, the past work would be unable to be performed.

Q Okay. Would there be any other work within this hypothetical?

A Yes, Your Honor, yeah, and I will provide three examples of position. And the three positions that we'll be identifying, the national numbers will be reduced by one third due to the need

for a sit/stand option based on this hypothetical. As a telephone order clerk, which is DOT code 209.567-014. This is considered unskilled, SVP 2, and performed at the sedentary exertional level, with approximately 55,000 jobs nationally. That is five five. As an assembler, DOT code 713 -- oh my apologies, Your Honor. I meant to state as an inspector, DOT code 669 --

Q Oh, you're a little ahead of me there. Gotta erase --

A That's no problem.

Q -- something and then if I can, inspector, DOT code?

A 669.687-014. This is considered unskilled, SVP 2, and performed at the sedentary exertional level, with approximately 13,000 jobs nationally, that is one three. And as a credit clerk, DOT code 205.367-014. This is considered unskilled, SVP 2, and performed at the sedentary exertional level with approximately 45,000 jobs nationally, that is four five, Your Honor.

Q Okay, thank you. If the hypothetical individual, due to chronic pain and loss of focus and concentration, and the need for additional periods of rest, would not be able to maintain adequate attention to work, resulting in being off task in excess of 25 percent of the work day, and absent more than four days per month, would this hypothetical individual be able to perform any past or other work?

A No, Your Honor, I would be unable to identify work.

Q And what are employer tolerances for time off task and absenteeism?

A In my vocational experience, Your Honor, approximately ten percent or more time off task would not be tolerated, and even one or more absences per month on an ongoing monthly basis would also not be tolerated.

Q Thank you. And is all of your testimony consistent with the DOT, and your education and experience as a vocational expert?

A Yes, Your Honor.

ALJ: Thank you very much. Mr. Foster, your witness.

ATTY: I have no further questions, Your Honor.

ALJ: Okay. Thank you very much, Mr. Fosberg. Enjoy your lunch, and we'll call you back when we're ready to start our afternoon cases.

VE: Thank you, Your Honor.

ALJ: You're welcome. And Mr. Foster, is there anything that you would like to say in summation today?

ATTY: The, just as a closing statement, I would just point out that the claimant suffers from numerous physical and mental impairments that her testimony should be entitled to heightened credibility, giving her long consistent work history, and her candidness about her symptoms. And then additionally, she does suffer from severe side effects as result of all of the medication she's taking. And we would certainly feel that her testimony is consistent with the second hypothetical in which, where she would be off task too much to remain employed in a competitive work environment, and she would also have excessive absenteeism,

rendering her unable to work in a competitive work environment. And we just would ask you to take all of that into consideration as you render your decision.

ALJ: Okay, thank you very much. Ma'am, it was nice speaking with you this morning. After today's hearing, I'll take the opportunity to go back over the evidence in your case, and your testimony, and Mr. Fosberg's testimony. I will be issuing a written decision, and you'll receive that in the mail. Okay?

CLMT: Okay, thank you. Mm-hmm.

ALJ: You're welcome. So everyone have, a nice afternoon and we can go off the record, Janet.

HR: Off the record.

ALJ: Okay, and it was nice working with you, Janet.

(The hearing closed at 12:06 PM, on July 22, 2020.)

C E R T I F I C A T I O N

I have read the foregoing and hereby certify that it is a true and complete transcription of the testimony recorded at the hearing in the case of JENNIFER LYN BROWN, held before Administrative Law Judge David Romeo.

/s/ Samantha Castronovo

Samantha Castronovo, Transcriber
Office of Appellate Operations

/s/ Felecia Hurley

Felecia Hurley, Proofreader
Office of Appellate Operations



Office of Disability Adjudication and Review
Stegmaier Bldg, St 201
7 N Wilkes Barre Blvd
Wilkes Barre, PA 18702

Date: October 27, 2015

Jennifer Lyn Brown
PO Box 952
Sayre, PA 18840

Notice of Dismissal

I am dismissing your request for a hearing. Please read this notice and the enclosed Order of Dismissal.

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If you disagree with my order, you may file an appeal with the Appeals Council. You may also ask me to vacate, or set aside, my order. Asking me to vacate my Order of Dismissal does not extend your time to file an appeal with the Appeals Council.

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Jennifer Lyn Brown (132-58-2507)

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- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
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Jennifer Lyn Brown (132-58-2507)

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Social Security
1 Elizabeth Street
Suite 1
Towanda, PA 18848-1656

Richard Zack
Administrative Law Judge

Enclosures:
Decision Rationale

cc: Peter Gorton
PO Box 89
Endicott, NY 13761-0089

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

IN THE CASE OF

Jennifer Lyn Brown
(Claimant)

(Wage Earner)

CLAIM FOR

Period of Disability and Disability Insurance
Benefits

132-58-2507

(Social Security Number)

ORDER OF DISMISSAL

This case is before the undersigned on a request for hearing dated November 5, 2014. The claimant is represented by Peter Gorton, an attorney.

An Administrative Law Judge may dismiss a request for hearing if, at any time before the notice of the hearing decision is mailed, the claimant asks to withdraw the request (20 CFR 404.957(a)).

By letter dated September 29, 2015, the claimant, through her representative, asked to withdraw the request for hearing. The record shows that the claimant was fully advised of the effects of this action, including dismissal of the request for hearing with the result that the initial determination would remain in effect. The undersigned is satisfied that the claimant understands the effects of her withdrawal of the request for hearing.

Accordingly, the claimant's request for hearing dated November 5, 2014 is dismissed and the initial determination dated October 29, 2014 remains in effect.

/s/ *Richard Zack*

Richard Zack
Administrative Law Judge
October 27, 2015
Date

Disability Determination Explanation**EXHIBIT NO. B2A****PAGE: 1 OF 13**

This Disability Determination Explanation is for the *DIB* claim at the *Initial* level.

CLAIMANT INFORMATION**CLAIMANT INFORMATION****Name:** Jennifer Lyn Brown**SSN:** 132-58-2507**Phone Number:** 607-215-0584**Secondary Phone Number****Address:**

Mailing	Residence
14 MAIN ST LOT 429 WELLSBURG, NY 14894	14 MAIN ST LOT 429 WELLSBURG, NY 14894 - 9741

Claimant Gender: F**Self Reported Height:** 71 inches**Self Reported Weight:** 286.0 lbs**BMI:** 39.9**Special Indications:** None.**RELEVANT DATES****Below table represents the Relevant Dates**

Date of Birth	Current Age	AOD	Age at AOD	DFI	DLI	Age at DLI	Blind DLI
10/26/1976	42 years 10 months (Younger person)	06/19/2019	42 years 7 months (Younger person)	04/01/2014	12/31/2023		

Does the individual have an attorney/appointed representative? No**ALLEGATIONS OF IMPAIRMENTS**

The individual filed for Initial claim for disability on 06/19/2019 due to the following illnesses, injuries or conditions:

Rheumatoid Arthritis
Crohn's Disease
Depression
Anxiety

The individual alleges inability to function and/or work as of
06/19/2019

Is the individual working?

No

Prior Electronic Filings

Prior Electronic Filing	Claim Level	Claim Type	Status	Initial Application Filing Date	Protective Filing Date	Determination or Decision Date	AC Remand Date
1	Hearing	DIB	Closed	08/20/2014		10/22/2015	
1	Initial	DIB	Closed	08/20/2014		10/29/2014	

Disclaimer: The Determination or Decision Date in the table above is propagated from the Decision Date field in eView, and may be later than the date on the Determination or Decision notice. A Determination or Decision (initial or revised) is final as of the date of the notice. Refer to DI 27501.001A for exceptions.

Alleged Onset Date:

06/19/2019

Has the individual performed work after the Alleged Onset Date(AOD)?

No

Has any period(s) of work been determined to be an unsuccessful work attempt, or involved subsidies/special conditions, impairment-related work expenses, or other technical issue(s)?

No

EVIDENCE OF RECORD

The following initial evidence has been received

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
EF Received	09/04/2019
Medical Opinion	Yes
Evidence Type	CE Rprt
Level	Initial
Opinion	1 of 1
Source Name	Gilbert Jenouri MD
Medical Opinion Date	08/21/2019
Is the Medical Opinion from an Acceptable Medical Source	Yes

Document Medical Opinion

Mild restriction walking and standing long periods, bending, stair climbing, lifting and carrying.

Source of Evidence	JAMES FREEMAN MD
EF Received	08/29/2019
Medical Opinion	No
Evidence Type	MER

Level	Initial
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Source of Evidence	PREETIKA SINH MD
EF Received	08/28/2019
Medical Opinion	No Evidence
Evidence Type	MER
Level	Initial

Source of Evidence	MICHAEL GILLAN DO
EF Received	08/28/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
EF Received	08/28/2019
Medical Opinion	Yes
Evidence Type	CE Rprt
Level	Initial

Opinion	1 of 1
Source Name	Amanda Slowik, Psy.D
Medical Opinion Date	08/21/2019
Is the Medical Opinion from an Acceptable Medical Source	Yes

Document Medical Opinion

Mild limitations in complex directions and instructions
Moderate limitations in interactions with others.
Difficulties are caused by distractibility, anxiety, and a low mood.

Source of Evidence	PREETIKA SINH MD
EF Received	08/13/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	ROBERT PACKER HOSPITAL
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EF Received	07/16/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	NONE
EF Received	07/15/2019
Medical Opinion	No Evidence
Evidence Type	ADL's
Level	Initial

Source of Evidence	Unknown Name
EF Received	07/13/2019
Medical Opinion	No Evidence
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	THOMAS J. MCDONALD MD
EF Received	07/12/2019
Medical Opinion	No Evidence
Evidence Type	MER
Level	Initial

Source of Evidence	HIT Extract
EF Received	06/27/2019
Medical Opinion	No
Evidence Type	HIT Extract
Level	Initial

Source of Evidence	Guthrie Health System
EF Received	06/27/2019
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

The following evidence has been requested:

Source of Evidence	EF Request Date	Level
LYNN SCHUTT FNP	09/17/2019	Initial
LYNN SCHUTT FNP	09/10/2019	Initial
PREETIKA SINH MD	08/02/2019	Initial
MICHAEL GILLAN DO	08/02/2019	Initial
JAMES FREEMAN MD	08/02/2019	Initial
PREETIKA SINH MD	07/23/2019	Initial
MICHAEL GILLAN DO	07/23/2019	Initial
JAMES FREEMAN MD	07/23/2019	Initial
MICHEAL GEORGETSON MD	07/18/2019	Initial
Unknown Name	07/12/2019	Initial
Unknown Name	07/12/2019	Initial
THOMAS MCDONALD MD	07/11/2019	Initial
MICHEAL GEORGETSON MD	07/08/2019	Initial
ROBERT PACKER HOSPITAL	07/08/2019	Initial
ROBERT PACKER HOSPITAL	07/08/2019	Initial
Unknown Name	07/01/2019	Initial
Unknown Name	07/01/2019	Initial
ROBERT PACKER HOSPITAL	07/01/2019	Initial
THOMAS MCDONALD MD	07/01/2019	Initial
ROBERT PACKER HOSPITAL	07/01/2019	Initial

CLAIM COMMUNICATIONS

No general claim communications have been created.

CONSULTATIVE EXAMINATION(S) (CE)

Is a CE(s) required?

Yes

Select the reason(s) for which a CE(s) is required:

The evidence as a whole, both medical and non-medical, is not sufficient to support a decision on the claim.

Was the individual's medical source(s) contacted to perform the CE(s)?

No

Indicate which of the following apply:

The individual's medical source(s) is unwilling to perform the CE(s) (such as when the source does not accept the state approved vendor fee)

Were all of the CE(s) kept?

Yes

Analysis

This 42.8 y/o F alleges disability under Title II due to rheumatoid arthritis, Crohn's disease, depression and anxiety. She has 2 years of college and one previous job as a supervisor of office operations at a hospital, in which she supervised 17 people.

Significant amount of MER in file, however it does not address the complaints listed on 3368. CE's ordered.

10/13/18 labs indicate drug induced lupus or SLE.

8/28/18 arthritis flare up.

1/2/19 Dx RA.

1/23/19 10 PT visits for dorsal forearm pain, no improvement.

1/31/19 Claimant had brain fog and memory issues.

3/1/19 MRI of shoulder reviewed. Mild AC arthritis.

4/17/19 3 trigger point injections.

5/24/19 L shoulder arthroscopic decompression and distal clavicle excision.

6/21/19 Pelvis enterography showed no evidence of active enteritis, stricture, fistulization or abscess.

7/10/19 ESR normal, Crohn's well controlled.

8/21/19 Physical CE -

Crohn's medically managed and stable. Sleep apnea on CPAP.

BMI at exam 38.6

Claimant appeared to be in no acute distress. Normal gait and stance. Could squat 50% of full and walk on heels and toes without difficulty. Needed no help changing for exam or getting on and off exam table. Able to rise from chair without difficulty.

Head and face, eyes, ENT, neck, chest and lungs, heart, abdomen, skin and neuro all normal.

Musculoskeletal limited as follows: Cervical spine flexion 40 degrees, extension 30 degrees, lateral flexion 20 degrees bilaterally and rotation 70 degrees bilaterally. Lumbar spine flexion 90 degrees, extension 20 degrees, lateral flexion 30 degrees bilaterally and rotation 30 degrees bilaterally. SLR 70 degrees positive bilaterally, not confirmed seated. Shoulder forward elevation right 150 degrees and left 100 degrees. Hip flexion/extension 80 degrees bilaterally, backward extension 20 degrees bilaterally. abduction 30 degrees bilaterally and adduction 10 degrees bilaterally. Knee flexion/extension full on right, left 0-130 degrees. All other tests full ROM/WNL. Trigger points for fibromyalgia bilateral shoulders, lumbar area, and knees.

Strength 5/5 in upper and lower extremities. Hand and finger dexterity intact; grip strength 5/5 right, 4/5 left. Able to zip, button and tie.

Xray of left shoulder and right hand negative.

416 - MEDICAL EVALUATION

No 416-Medical Evaluation have been associated with this claim.

MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY (MDI)

ADULT MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)

Does the individual have one or more medically determinable impairments?

Yes

<u>IMPAIRMENT</u>	<u>PRIORITY</u>	<u>SEVERITY</u>
7160 - Other and Unspecified Arthropathies	Primary	Severe
5550 - Inflammatory Bowel Disease (IBD)	Other	Severe
3000 - Anxiety and Obsessive-Compulsive Disorders	Secondary	Non Severe

PSYCHIATRIC REVIEW TECHNIQUE (PRT)

PRT1

Indicate whether this Psychiatric Review Technique (PRT) assessment is for:

Current Evaluation

'A' CRITERIA OF THE LISTINGS

12.04-Depressive, Bipolar, and Related Disorders

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above

12.06-Anxiety and Obsessive-Compulsive Disorders

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above

'B' CRITERIA OF THE LISTINGS

12.04-Depressive, Bipolar, and Related Disorders

12.06-Anxiety and Obsessive-Compulsive Disorders

Understand, remember, or apply information: None

Interact with others: None

Concentrate, persist, or maintain pace: Mild

Adapt or manage oneself: Mild

'C' CRITERIA OF THE LISTINGS

Evidence does not establish the presence of the "C Criteria"

PRT - ADDITIONAL EXPLANATION

The clmt is a 42 yr old female alleging disability due to anxiety, depression, and physical problems.

Clmt denies hospitalizations or current outpatient therapy.

January 2019 visit clmt c/o trouble concentrating and brain fog in the context of bereavement following loss of her father. PE noted normal judgment and behavior, normal affect and cognition, no depressed mood. Primary care prescribes Wellbutrin and Effexor.

Consultant MSE noted anxious affect, c/o depressive sx, but MSE was generally unremarkable. Assessment of bereavement, unspecified anxiety disorder.

CLmt is independent in ADLs, reports some supportive family relationships and she keeps in touch with friends.

Based on the totality of the evidence, the clmt's mental impairments have no more than a minimal impact on her ability to function on a daily basis. Impairments are non severe.

These findings complete the medical portion of the disability determination.

MC/PC or SDM Signature

M. Marks, PhD (38) 09/05/2019

ADULT LISTINGS CONSIDERED

<u>Listing</u>	<u>Description</u>	<u>Subsection</u>	<u>PRT Assessment</u>
12.04	Depressive, Bipolar and		PRT 1

12.06

Related Disorders
Anxiety and
Obsessive-Compulsive
Disorders**ADULT MEDICAL DISPOSITION**

RFC Assessment Necessary (Physical and/or Mental)

ASSESSMENT OF POLICY ISSUES**SYMPTOMS EVALUATION****List the claimant's symptoms:**

Pain
 Malaise
 Weakness
 Understanding and memory limitations
 Sustained concentration and persistence limitations
 Social interaction limitations
 Ability to adapt limitations

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

No

When considering the following factors, which were the most informative in assessing the consistency of the individual's statements about their symptom related limitations with all the evidence in file?

ADLs
 Medication Treatment
 Treatment other than medication
 Inconsistency of the claimant's allegations with the opinion evidence

What is your assessment of the consistency of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file?

Partially Consistent

Assessment of consistency regarding symptom related limitations:

After considering the evidence of record, this determination finds that the claimant's medically determinable impairments could have reasonably been expected to produce the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are partially consistent with the evidence of record.

EVALUATING MEDICAL OPINIONS**The following displays medical opinions from all sources:**

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
Source Name	Gilbert Jenouri MD
Level	Initial
Medical Opinion Date	08/21/2019
AMS	Yes

Document how you considered supportability and consistency

Opinion of medical source above was considered in this assessment as it is supported and consistent with other medical evidence in file.

EXHIBIT NO. B2A
PAGE: 9 OF 13

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
Source Name	Amanda Slowik, Psy.D
Level	Initial
Medical Opinion Date	08/21/2019
AMS	Yes
Document how you considered supportability and consistency	Opinion of medical source above was considered in this assessment as it is supported and consistent with other medical evidence in file.

RESIDUAL FUNCTIONAL CAPACITY

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

RFC1

Indicate whether this Physical Residual Functional Capacity (RFC) assessment is for:

12 Months After Onset: 06/18/2020

Does the individual have exertional limitations?

Yes

Rate the individual's exertional limitations:

Occasionally (occasionally is cumulatively 1/3 or less of an 8 hour day) lift and/or carry (including upward pulling):

20 pounds

Frequently (frequently is cumulatively more than 1/3 up to 2/3 of an 8 hour day) lift and/or carry (including upward pulling):

10 pounds

Stand and/or walk (with normal breaks) for a total of:

About 6 hours in an 8-hour workday

Sit (with normal breaks) for a total of:

About 6 hours in an 8-hour workday

Push and/or pull (including operation of hand and/or foot controls):

Unlimited, other than shown, for lift and/or carry

Explain exertional limitations and how and why the evidence supports your conclusions. Cite specific facts upon which your conclusions are based:

See forms in file

Does the individual have postural limitations?

Yes

Rate the individual's postural limitations:

Climbing Ramps/stairs: Frequently

Climbing Ladders/ropes/scaffolds: Frequently

Balancing: Unlimited

Stooping (i.e., bending at the waist): Frequently

Kneeling: Frequently

Crouching (i.e., bending at the knees): Frequently

Crawling: Frequently

Explain postural limitations and how and why the evidence supports your conclusions. Cite specific facts upon which your conclusions are based:

Limited to frequently due to reduced ROM and joint pain

Does the individual have manipulative limitations?

Yes

Rate the individual's manipulative limitations:

Reaching any direction (including overhead):

Unlimited

Handling (gross manipulation): Limited

Left

Fingering (fine manipulation): Unlimited

Feeling (skin receptors): Unlimited

Explain manipulative limitations and how and why the evidence supports your conclusions. Cite specific facts upon which your conclusions are based (include the extent to which the function can be performed – e.g., constantly, frequently, occasionally, never, etc.):

limited to frequently for handling on left due to reduced grip strength. Dexterity intact on the CE exam.

EMG of the bilateral upper extremities performed 11/2/18 was normal.

Does the individual have visual limitations?

No

Does the individual have communicative limitations?

No

Does the individual have environmental limitations?

No

RFC – Additional Explanation

This 42 y/o F alleges disability under Title II due to rheumatoid arthritis, Crohn's disease, and mental health complaints.

Objective medical evidence as follows:

7//18 right knee xray is negative.
 8/8/18 right thumb xray is negative.
 9/24/18 left shoulder xray is negative.
 10/13/18 labs indicate drug induced lupus or SLE.
 8/28/18 arthritis flare up.
 1/2/19 Dx RA.
 1/23/19 10 PT visits for dorsal forearm pain, no improvement.
 1/31/19 Claimant had brain fog and memory issues.
 3/1/19 MRI of shoulder reviewed. Mild AC arthritis.
 4/17/19 3 trigger point injections.
 4/18/19 CT of brain was performed in ED for acute headache and this is normal.
 5/24/19 L shoulder arthroscopic decompression and distal clavicle excision. The rotator cuff is intact.
 6/21/19 Pelvis enterography showed no evidence of active enteritis, stricture, fistulization or abscess.
 7/10/19 ESR normal, Crohn's well controlled.

8/21/19 Physical CE -
 Crohn's medically managed and stable. Sleep apnea on CPAP.

Claimant appeared to be in no acute distress. Normal gait and stance. Could squat 50% of full and walk on heels and toes without difficulty. Needed no help changing for exam or getting on and off exam table. Able to rise from chair without difficulty.
 Head and face, eyes, ENT, neck, chest and lungs, heart, abdomen, skin and neuro all normal.

Musculoskeletal limited as follows: Cervical spine flexion 40 degrees, extension 30 degrees, lateral flexion 20 degrees bilaterally and rotation 70 degrees bilaterally. Lumbar spine flexion 90 degrees, extension 20 degrees, lateral flexion 30 degrees bilaterally and rotation 30 degrees bilaterally. SLR 70 degrees positive bilaterally, not confirmed seated. Shoulder forward elevation right 150 degrees and left 100 degrees. Hip flexion/extension 80 degrees bilaterally, backward extension 20 degrees bilaterally. abduction 30 degrees bilaterally and adduction 10 degrees bilaterally. Knee flexion/extension full on right, left 0-130 degrees. All other tests full ROM/WNL.
 Trigger points for fibromyalgia bilateral shoulders, lumbar area, and knees.
 Strength 5/5 in upper and lower extremities. Hand and finger dexterity intact; grip strength 5/5 right, 4/5 left. Able to zip, button and tie.
 Xray of left shoulder and right hand negative at CE.

BMI at exam of 38.6 has been considered as an additional adversity and factored into the RFC.

Although the claimant has a severe MDI at present, it is projected that she will be able to function as stated above on or before 6/18/2020.

These findings complete the medical portion of the disability determination.

MC/PC or SDM Signature

J.Koenig MD 34 09/09/2019

ASSESSMENT OF POLICY ISSUES – CONTINUED

RECONCILING MEDICAL OPINIONS

Are there medical opinions about the individual's abilities and limitations that are more restrictive than your findings?

No

ASSESSMENT OF VOCATIONAL FACTORS**ASSESSMENT OF THE INDIVIDUAL'S ABILITY TO PERFORM PAST RELEVANT WORK**

A finding about the capacity for PRW has not been made. However, this information is not material because all potentially applicable Medical-Vocational Guidelines would direct a finding of "not disabled" given the individual's age, education, and RFC. Therefore, the individual can adjust to other work.

Past Relevant Work:

Past Relevant Work is expedited.

Additional Past Work Titles:

Job Title:	Supervisor Office Operations
Start Date:	JANUARY 2000
End Date:	JUNE 2019

APPLICATION OF MEDICAL - VOCATIONAL RULES: Other Work

Past Relevant Work is expedited.

Is the individual limited to unskilled work because of the impairments?

No

Based on the seven strength factors of the physical RFC (lifting/carrying, standing, walking, sitting, pushing, and pulling), the individual demonstrates the maximum sustained work capability for the following:

LIGHT

The highest grade of school completed by the individual is:

14

Indicate the rule used to direct a determination or as a framework.

202.21 - Young HS Skilled-Semi No Trans

Select one of the following:

Rule Used as a Framework

Cite up to three occupations in which there are a significant number of jobs that exist in the national economy, select the appropriate Social Security Ruling (SSR), OR select the appropriate exception:

83-10: Other Work: The medical-vocational rules of appendix 2

DETERMINATION

Based on the documented findings, select the determination:

Not Disabled

Is there medical evidence of DAA?

There is no evidence of any substance abuse disorder /DAA issue

3

Indicate which of the following Acquiescence Rulings are applicable

None of the ARs considered apply to this claim

REGULATION BASIS CODE (RBC)

Regulation Basis Code:

E3-20CFR404.1509-DIB CLAIM

PERSONALIZED DISABILITY EXPLANATION (PDE)

PDE Text:

x

PDE Continued:

x

SIGNATURES

MC/PC or SDM Signature

J.Koenig MD 34 09/09/2019

Disability Adjudicator/Examiner Signature:

K. Adalian 09/18/2019

eCAT version: 10.6.32

DISABILITY DETERMINATION AND TRANSMITTAL

EXHIBIT NO. B3A

PAGE: 1 OF 1

1. DESTINATION DDS ODO DRS DQB INTPSC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		2. DDS CODE V17	3. FILING DATE 06/19/19	4. SSN 132-58-2507 BIC (if CDB or DWB CLA	
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code) JENNIFER L BROWN 14 MAIN ST LOT 429 WELLSBURG NY 14894-				6. WE'S NAME (if CDB or DWB CLAIM) JENNIFER L BROWN	
				7. TYPE CLAIM (Title 02) DIB	
				8. TYPE CLAIM (Title 16)	
9. DATE OF BIRTH 10/26/1976		10. PRIOR ACTION PD <input type="checkbox"/> PT <input type="checkbox"/>		11. REMARKS PHONE (607-215-0584), AOD (06/19/19), SLC (7), DLI 12/31/23) XREF SSN/BIC (132-58-2507/),	
12. DISTRICT-BRANCH OFFICE ADDRESS (Include ZIP Code) SOCIAL SECURITY ADMIN PO BOX 317500 JAMAICA NY 11431-			DO-BO CODE C25		
13. DO-BO REPRESENTATIVE			14. DATE	11A. <input type="checkbox"/> Presumptive Disability	11B. <input type="checkbox"/> Impairment
DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED					
15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS BODY SYS. 01 Other and Unspecified Arthropathies		CODE NO. 7160	16B. SECONDARY DIAGNOSIS Anxiety Related Disorder/Functional Nonpsychotic
17. DIARY TYPE MO/YR /		REASON			
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/216(i) Not Disab. for Cash Bene. A. <input type="checkbox"/> Purp. Disab. for Cash Benefit B. <input type="checkbox"/> Purp Beg.			19. CLAIMANT NOT DISABLED Through Date of Before Age 22 A. <input checked="" type="checkbox"/> Current Determination B. <input type="checkbox"/> Through C. <input type="checkbox"/> (CDB only)		
20. VOCATIONAL BACKGROUND			OCC YRS.	ED YRS 14	21. VR SC IN SC OUT Prev Ref ACTION A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/>
22. REG-BASIS CODE E3	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input type="checkbox"/>	25A. Initial Recon Recon DHU A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/>	ALJ Hearing Appeals Council U.S. District Court D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/>
26 LIST NO. <input type="checkbox"/>	A.	B.	C.	D.	E.
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4 <input checked="" type="checkbox"/> Check if Vocational Rule Met. Cite Rule <input type="checkbox"/> 202.21					
28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Etab Beg. AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term					
29. LTR/PAR NO. Y	30. DISABILITY EXAMINER-DDS K ADALIAN		31. DATE 09/18/19	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE RFC1 in DDE 09/09/2019	
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) J KOENIG MD					32B. SPEC. CODE 34
34. REMARKS					MULTIPLE IMPAIRMENTS CONSIDERED 34A. COMBINED MULTIPLE NONSEVERE-SEVERE 34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE
35. BASIS CODE	36. REV.DET. CODES	37. SSA REPRESENTATIVE			SSA CODE
					38. DATE

Disability Determination Explanation

EXHIBIT NO. B4A
PAGE: 1 OF 14

This Disability Determination Explanation is for the *DIB* claim at the *Reconsideration* level.

CLAIMANT INFORMATION

CLAIMANT INFORMATION

Name: Jennifer Lyn Brown

SSN: 132-58-2507

Phone Number: 607-215-0584

Secondary Phone Number: 607-483-1886

Address:

Mailing	Residence
14 MAIN ST LOT 429 WELLSBURG, NY 14894	14 MAIN ST LOT 429 WELLSBURG, NY 14894 - 9741

Claimant Gender: F

Self Reported Height: 71 inches

Self Reported Weight: 286.0 lbs

BMI: 39.9

Special Indications: None.

RELEVANT DATES

Below table represents the Relevant Dates

Date of Birth	Current Age	AOD	Age at AOD	DFI	DLI	Age at DLI	Blind DLI
10/26/1976	43 years 1 month (Younger person)	06/19/2019	42 years 7 months (Younger person)	04/01/2014	12/31/2023		

Does the individual have an attorney/appointed representative? Yes

Representative's name, address and phone number:

Jonathan Paul Foster
303 SOUTH KEYSTONE AVE
SAYRE, PA 18840 - 1525
570-888-1529

ALLEGATIONS OF IMPAIRMENTS

The individual filed for Initial claim for disability on 06/19/2019 due to the following illnesses, injuries or conditions:

The individual alleges inability to function and/or work as of
06/19/2019

RECONSIDERATION ISSUES

Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?

Yes

Approximate date the change occurred: October 2, 2019

Claimant-supplied Information:

Worse pain, unable to function some days, has hard time getting up/down, hands hot, inflamed, and medications added.

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?

Yes

Approximate date of new conditions: July 17, 2019

Claimant-supplied Information:

Enteropathic Arthritis

Does the prior determination substantively and technically resolve all pertinent adjudicative issues?

Yes

Has the individual worked since last completing a disability report?

No

Prior Electronic Filings

Prior Electronic Filing	Claim Level	Claim Type	Status	Initial Application Filing Date	Protective Filing Date	Determination or Decision Date	AC Remand Date
1	Hearing	DIB	Closed	08/20/2014		10/22/2015	
1	Initial	DIB	Closed	08/20/2014		10/29/2014	
Disclaimer: The Determination or Decision Date in the table above is propagated from the Decision Date field in eView, and may be later than the date on the Determination or Decision notice. A Determination or Decision (initial or revised) is final as of the date of the notice. Refer to <u>DI 27501.001A</u> for exceptions.							

Alleged Onset Date:

06/19/2019

Has the individual performed work after the Alleged Onset Date(AOD)?

No

Has any period(s) of work been determined to be an unsuccessful work attempt, or involved subsidies/special conditions, impairment-related work expenses, or other technical issue(s)?

No

EVIDENCE OF RECORD

The following reconsideration evidence has been received

Evidence	
EF Received	12/06/2019
Medical Opinion	No
Evidence Type	ADL's
Level	Reconsideration

Source of Evidence	HIT Extract #2
EF Received	10/24/2019
Medical Opinion	No
Evidence Type	HIT Extract
Level	Reconsideration

Source of Evidence	Guthrie Health System #2
EF Received	10/24/2019
Medical Opinion	No
Evidence Type	HIT MER
Level	Reconsideration

The following initial evidence has been received

Source of Evidence	Unknown Name
EF Received	09/20/2019
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
EF Received	09/04/2019
Medical Opinion	Yes
Evidence Type	CE Rprt
Level	Initial

Opinion	1 of 1
Source Name	Gilbert Jenouri MD
Medical Opinion Date	08/21/2019
Is the Medical Opinion from an Acceptable Medical Source	Yes

Document Medical Opinion

Mild restrictions in complex directions and instructions. Moderate limitations in interactions with others. Difficulties are caused by distractibility, anxiety, and a low mood.

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EXHIBIT NO. B4A**PAGE: 4 OF 14**

Source of Evidence	JAMES FREEMAN MD
EF Received	08/29/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	PREETIKA SINH MD
EF Received	08/28/2019
Medical Opinion	No Evidence
Evidence Type	MER
Level	Initial

Source of Evidence	MICHAEL GILLAN DO
EF Received	08/28/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
EF Received	08/28/2019
Medical Opinion	Yes
Evidence Type	CE Rprt
Level	Initial

Opinion	1 of 1
Source Name	Amanda Slowik, Psy.D
Medical Opinion Date	08/21/2019
Is the Medical Opinion from an Acceptable Medical Source	Yes

Document Medical Opinion

Mild limitations in complex directions and instructions
 Moderate limitations in interactions with others.
 Difficulties are caused by distractibility, anxiety, and a low mood.

Source of Evidence	PREETIKA SINH MD
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EF Received	08/13/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	ROBERT PACKER HOSPITAL
EF Received	07/16/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	NONE
EF Received	07/15/2019
Medical Opinion	No Evidence
Evidence Type	ADL's
Level	Initial

Source of Evidence	Unknown Name
EF Received	07/13/2019
Medical Opinion	No Evidence
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	THOMAS J. MCDONALD MD
EF Received	07/12/2019
Medical Opinion	No Evidence
Evidence Type	MER
Level	Initial

Source of Evidence	HIT Extract
EF Received	06/27/2019
Medical Opinion	No
Evidence Type	HIT Extract
Level	Initial

Source of Evidence	Guthrie Health System
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EF Received	06/27/2019	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 94 of 1112	EXHIBIT NO. B4A
Medical Opinion	No		PAGE: 6 OF 14
Evidence Type	HIT MER		
Level	Initial		

The following evidence has been requested:

Source of Evidence	EF Request Date	Level
Unknown Name	11/18/2019	Reconsideration
Unknown Name	11/07/2019	Reconsideration
Unknown Name	11/07/2019	Reconsideration
Unknown Name	11/07/2019	Reconsideration
Unknown Name	11/07/2019	Reconsideration
Unknown Name	10/28/2019	Reconsideration
Unknown Name	10/28/2019	Reconsideration
LYNN SCHUTT FNP	09/17/2019	Initial
LYNN SCHUTT FNP	09/10/2019	Initial
MICHEAL GEORGETSON MD	07/18/2019	Initial
Unknown Name	07/12/2019	Initial
Unknown Name	07/12/2019	Initial
MICHEAL GEORGETSON MD	07/08/2019	Initial
Unknown Name	07/01/2019	Initial
Unknown Name	07/01/2019	Initial

CLAIM COMMUNICATIONS

No general claim communications have been created.

CONSULTATIVE EXAMINATION(S) (CE)

Is a CE(s) required?

Yes

Select the reason(s) for which a CE(s) is required:

The evidence as a whole, both medical and non-medical, is not sufficient to support a decision on the claim.

Was the individual's medical source(s) contacted to perform the CE(s)?

No

Indicate which of the following apply:

The individual's medical source(s) is unwilling to perform the CE(s) (such as when the source does not accept the state approved vendor fee)

Were all of the CE(s) kept?

Yes

FINDINGS OF FACT AND ANALYSIS OF EVIDENCE

08/22/2019 REQUESTING PHYSICAL THERAPY DUE TO LEFT ELBOW AND SHOULDER PAIN. LEFT ELBOW FINDS NORMAL ROM. LEFT SHOULDER TENDERNESS AND NORMAL ROM. DEPRESSION/ANXIETY WELL CONTROLLED

09/04/2019 GASTROENTEROLOGY F/U. STELARA IM CONTINUES.

09/2019 CLMT BEGINS PHYSICAL THERAPY FOR LEFT SHOULDER/LEFT ELBOW

10/02/2019 C/O WIDESPREAD MUSCULOSKELETAL PAIN INVOLVING THE UPPER BACK AND SPINE, NECK, SHOULDERS AND LOW BACK, SPINE, BUTTOCKS, ASSOCIATED WITH FATIGUE AND SLEEP DISTURBANCE. CROHNS WELL CONTROLLED. MEDICATION CHANGES. NOTED FOR NORMAL ROM. TENDERNESS IS PRESENT, DTR NORMAL.

10/3/2019 PT NOTES INDICATE IMPROVEMENT IN THE LEFT SHOULDER, ABLE TO LIE DOWN WITHOUT SIGNIFICANT PAIN. IMPROVE ROM

10/16/19 D/C NOTE IMPROVE TOLERANCE TO CARRYING GROCERIES, OVERHEAD ACTIVITIES. ABLE TO WALK HER DOGS. MINIMAL SHOULDER PAIN AT NIGHT.

416 – MEDICAL EVALUATION

No 416-Medical Evaluation have been associated with this claim.

MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY (MDI)

ADULT MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)

Does the individual have one or more medically determinable impairments?

Yes

<u>IMPAIRMENT</u>	<u>PRIORITY</u>	<u>SEVERITY</u>
7160 – Other and Unspecified Arthropathies	Primary	Severe
5550 – Inflammatory Bowel Disease (IBD)	Other	Severe
3000 – Anxiety and Obsessive-Compulsive Disorders	Secondary	Non Severe

PSYCHIATRIC REVIEW TECHNIQUE (PRT)

PRT1

Indicate whether this Psychiatric Review Technique (PRT) assessment is for:

Current Evaluation

'A' CRITERIA OF THE LISTINGS

12.04-Depressive, Bipolar, and Related Disorders

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above

12.06-Anxiety and Obsessive-Compulsive Disorders

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above

'B' CRITERIA OF THE LISTINGS

12.04-Depressive, Bipolar, and Related Disorders

12.06-Anxiety and Obsessive-Compulsive Disorders

Understand, remember, or apply information: None
Interact with others: None
Concentrate, persist, or maintain pace: Mild
Adapt or manage oneself: Mild

'C' CRITERIA OF THE LISTINGS

Evidence does not establish the presence of the "C Criteria"

PRT - ADDITIONAL EXPLANATION

The clmt is a 42 yr old female alleging disability due to anxiety, depression, and physical problems.

Clmt denies hospitalizations or current outpatient therapy.

January 2019 visit clmt c/o trouble concentrating and brain fog in the context of bereavement following loss of her father. PE noted normal judgment and behavior, normal affect and cognition, no depressed mood. Primary care prescribes Wellbutrin and Effexor.

Consultant MSE noted anxious affect, c/o depressive sx, but MSE was generally unremarkable. Assessment of bereavement, unspecified anxiety disorder.

CLmt is independent in ADLs, reports some supportive family relationships and she keeps in touch with friends.

Updated ADLs clmt endorses difficulties with attention, task completion, brain fog, physical problems, but does self-care, weekly meals, drives, shops online, some difficulties with handling funds but manages money, does not socialize but endorsed no difficulties getting along with others. Based on the totality of the evidence, the clmt's mental impairments have no more than a minimal impact on her ability to function on a daily basis. Impairments are non severe.

THERE IS NO ADDITIONAL EVIDENCE AND THE PRIOR DETERMINATION IS AFFIRMED

These findings complete the medical portion of the disability determination.

MC/PC Signature

C. Walker, PhD (38) 12/10/2019

ADULT LISTINGS CONSIDERED

<u>Listing</u>	<u>Description</u>	<u>Subsection</u>	<u>PRT Assessment</u>
12.04	Depressive, Bipolar and Related Disorders		PRT 1
12.06	Anxiety and Obsessive-Compulsive Disorders		PRT 1

ADULT MEDICAL DISPOSITION

RFC Assessment Necessary (Physical and/or Mental)

List the claimant's symptoms:

- Pain
- Malaise
- Weakness
- Understanding and memory limitations
- Sustained concentration and persistence limitations
- Social interaction limitations
- Ability to adapt limitations

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

No

When considering the following factors, which were the most informative in assessing the consistency of the individual's statements about their symptom related limitations with all the evidence in file?

- ADLs
- Medication Treatment
- Treatment other than medication
- Inconsistency of the claimant's allegations with the opinion evidence

What is your assessment of the consistency of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file?

Partially Consistent

Assessment of consistency regarding symptom related limitations:

After considering the evidence of record, this determination finds that the claimant's medically determinable impairments could have reasonably been expected to produce the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are partially consistent with the evidence of record.

EVALUATING MEDICAL OPINIONS

The following displays medical opinions from all sources:

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
Source Name	Gilbert Jenouri MD
Level	Initial
Medical Opinion Date	08/21/2019
AMS	Yes
Document how you considered supportability and consistency	Opinion of medical source above was considered in this assessment as it is supported and consistent with other medical evidence in file.

Source of Evidence	INDUSTRIAL MEDICINE ASSOC PC
Source Name	Amanda Slowik, Psy.D
Level	Initial
Medical Opinion Date	08/21/2019
AMS	Yes

RESIDUAL FUNCTIONAL CAPACITY

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

RFC1

Indicate whether this Physical Residual Functional Capacity (RFC) assessment is for:

12 Months After Onset: 06/18/2020

Does the individual have exertional limitations?

Yes

Rate the individual's exertional limitations:

Occasionally (occasionally is cumulatively 1 /3 or less of an 8 hour day) lift and/or carry (including upward pulling):

20 pounds

Frequently (frequently is cumulatively more than 1 /3 up to 2/3 of an 8 hour day) lift and/or carry (including upward pulling):

10 pounds

Stand and/or walk (with normal breaks) for a total of:

About 6 hours in an 8-hour workday

Sit (with normal breaks) for a total of:

About 6 hours in an 8-hour workday

Push and/or pull (including operation of hand and/or foot controls):

Unlimited, other than shown, for lift and/or carry

Explain exertional limitations and how and why the evidence supports your conclusions. Cite specific facts upon which your conclusions are based:

See forms in file

Obesity

HTN

Does the individual have postural limitations?

No

Does the individual have manipulative limitations?

No

Does the individual have visual limitations?

No

Does the individual have communicative limitations?

No

Does the individual have environmental limitations?

Yes

Rate the individual's environmental limitations:

Extreme cold: Unlimited

Wetness: Unlimited

Humidity: Unlimited

Noise: Unlimited

Vibration: Unlimited

Fumes, odors, dusts, gases, poor ventilation, etc.: Unlimited

Hazards (machinery, heights, etc.): Avoid concentrated exposure

Explain environmental limitations and how and why the evidence supports your conclusions. Cite specific facts upon which your conclusions are based:

OSA

RFC - Additional Explanation

This 42 y/o F alleges disability under Title II due to rheumatoid arthritis, Crohn's disease, and mental health complaints.

Objective medical evidence as follows:

7//18 right knee xray is negative.
8/8/18 right thumb xray is negative.
9/24/18 left shoulder xray is negative.
10/13/18 labs indicate drug induced lupus or SLE.
8/28/18 arthritis flare up.
1/2/19 Dx RA.
1/23/19 10 PT visits for dorsal forearm pain, no improvement.
1/31/19 Claimant had brain fog and memory issues.
3/1/19 MRI of shoulder reviewed. Mild AC arthritis.
4/17/19 3 trigger point injections.
4/18/19 CT of brain was performed in ED for acute headache and this is normal.
5/24/19 L shoulder arthroscopic decompression and distal clavicle excision. The rotator cuff is intact.
6/21/19 Pelvis enterography showed no evidence of active enteritis, stricture, fistulization or abscess.
7/10/19 ESR normal, Crohn's well controlled.

8/21/19 Physical CE -
Crohn's medically managed and stable. Sleep apnea on CPAP.

Claimant appeared to be in no acute distress. Normal gait and stance. Could squat 50% of full and

walk on heels and toes without difficulty. Needed no help changing for exam or getting on and off exam table. Able to rise from chair without difficulty.

Head and face, eyes, ENT, neck, chest and lungs, heart, abdomen, skin and neuro all normal.

Musculoskeletal limited as follows: Cervical spine flexion 40 degrees, extension 30 degrees, lateral flexion 20 degrees bilaterally and rotation 70 degrees bilaterally. Lumbar spine flexion 90 degrees, extension 20 degrees, lateral flexion 30 degrees bilaterally and rotation 30 degrees bilaterally. SLR 70 degrees positive bilaterally, not confirmed seated. Shoulder forward elevation right 150 degrees

and left 100 degrees. Hip flexion/extension 80 degrees bilaterally, backward extension 20 degrees bilaterally. abduction 30 degrees bilaterally and adduction 10 degrees bilaterally. Knees flexion/extension full on right, left 0-130 degrees. All other tests full ROM/WNL. Trigger points for fibromyalgia bilateral shoulders, lumbar area, and knees. Strength 5/5 in upper and lower extremities. Hand and finger dexterity intact; grip strength 5/5 right, 4/5 left. Able to zip, button and tie. Xray of left shoulder and right hand negative at CE.

BMI at exam of 38.6 has been considered as an additional adversity and factored into the RFC.

Although the claimant has a severe MDI at present, it is projected that she will be able to function as stated above on or before 6/18/2020.

43 YEAR OLD FEMALE REQUESTS RECONSIDERATION
CLMT ALLEGES INCREASED PAIN AND NEW DX ENTEROPATHIC ARTHRITIS

08/22/2019 REQUESTING PHYSICAL THERAPY DUE TO LEFT ELBOW AND SHOULDER PAIN. LEFT ELBOW FINDS NORMAL ROM. LEFT SHOULDER TENDERNESS AND NORMAL ROM.
DEPRESSION/ANXIETY WELL CONTROLLED
09/04/2019 GASTROENTEROLOGY F/U. STELARA IM CONTINUES.
09/2019 CLMT BEGINS PHYSICAL THERAPY FOR LEFT SHOULDER/LEFT ELBOW

10/02/2019 C/O WIDESPREAD MUSCULOSKELETAL PAIN INVOLVING THE UPPER BACK AND SPINE, NECK, SHOULDERS AND LOW BACK, SPINE, BUTTOCKS, ASSOCIATED WITH FATIGUE AND SLEEP DISTURBANCE. CROHNS WELL CONTROLLED. MEDICATION CHANGES. NOTED FOR NORMAL ROM. TENDERNESS IS PRESENT, DTR NORMAL.

10/3/2019 PT NOTES INDICATE IMPROVEMENT IN THE LEFT SHOULDER, ABLE TO LIE DOWN WITHOUT SIGNIFICANT PAIN. IMPROVE ROM
10/16/19 D/C NOTE IMPROVE TOLERANCE TO CARRYING GROCERIES, OVERHEAD ACTIVITIES. ABLE TO WALK HER DOGS. MINIMAL SHOULDER PAIN AT NIGHT.

ADDITIONAL EVIDENCE IS REVIED

These findings complete the medical portion of the disability determination.

MC/PC Signature

S.Naroditsky MD (19) 12/13/2019

ASSESSMENT OF POLICY ISSUES – CONTINUED

RECONCILING MEDICAL OPINIONS

Are there medical opinions about the individual's abilities and limitations that are more restrictive than your findings?

No

**ASSESSMENT OF VOCATIONAL
FACTORS****EXHIBIT NO. B4A
PAGE: 13 OF 14****ASSESSMENT OF THE INDIVIDUAL'S ABILITY TO PERFORM PAST RELEVANT WORK**

A finding about the capacity for PRW has not been made. However, this information is not material because all potentially applicable Medical-Vocational Guidelines would direct a finding of "not disabled" given the individual's age, education, and RFC. Therefore, the individual can adjust to other work.

Past Relevant Work:

Past Relevant Work is expedited.

Additional Past Work Titles:

Job Title:	Supervisor Office Operations
Start Date:	JANUARY 2000
End Date:	JUNE 2019

APPLICATION OF MEDICAL - VOCATIONAL RULES: Other Work

Past Relevant Work is expedited.

Is the individual limited to unskilled work because of the impairments?

No

Based on the seven strength factors of the physical RFC (lifting /carrying, standing, walking, sitting, pushing, and pulling), the individual demonstrates the maximum sustained work capability for the following:

LIGHT

The highest grade of school completed by the individual is:

14

Indicate the rule used to direct a determination or as a framework.

202.21 - Young HS Skilled-Semi No Trans

Select one of the following:

Rule Used as a Framework

Cite up to three occupations in which there are a significant number of jobs that exist in the national economy, select the appropriate Social Security Ruling (SSR), OR select the appropriate exception:

83-10: Other Work: The medical-vocational rules of appendix 2

DETERMINATION

Based on the documented findings, select the determination:

Not Disabled

Is there medical evidence of DAA?

There is no evidence of any substance abuse disorder /DAA issue

DIB Claim/265242165

Indicate which of the following Acquiescence Rulings are applicable

None of the ARs considered apply to this claim

REGULATION BASIS CODE (RBC)

Regulation Basis Code:

J1-20CFR404.1520(g)-DIB CLAIM

PERSONALIZED DISABILITY EXPLANATION (PDE)

PDE Text:

x

PDE Continued:

x

SIGNATURES

Adult MC/PC Signature

S.Naroditsky MD (19) 12/13/2019

This reconsideration file has been thoroughly reviewed to ensure that the total evidence of record is sufficient and consistent to support the proposed determination.

Disability Adjudicator/Examiner Signature:

A. Ossenfort 12/17/2019

eCAT version: 10.6.32

DISABILITY DETERMINATION AND TRANSMITTAL

EXHIBIT NO. B5A

PAGE: 1 OF 1

1. DESTINATION DDS ODO DRS DQB INTPSC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		2. DDS CODE V17	3. FILING DATE 06/19/19	4. SSN 132-58-2507 BIC (if CDB or DWB CLA	
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code) JENNIFER L BROWN 14 MAIN ST LOT 429 WELLSBURG NY 14894-				6. WE'S NAME (if CDB or DWB CLAIM) JENNIFER L BROWN	
				7. TYPE CLAIM (Title 02) DIB	
				8. TYPE CLAIM (Title 16)	
9. DATE OF BIRTH 10/26/1976		10. PRIOR ACTION PD <input type="checkbox"/> PT <input type="checkbox"/>		11. REMARKS PHONE (607-215-0584), AOD (06/19/19), SLC (7), DLI 12/31/23) RECON DATE (10/23/19), XREF SSN/BIC (132-58-2507/),	
12. DISTRICT-BRANCH OFFICE ADDRESS (Include ZIP Code) SOCIAL SECURITY ADMIN 3345 CHAMBERS RD HORSEHEADS NY 14845			DO-BO CODE 114		
13. DO-BO REPRESENTATIVE		14. DATE		11A. <input type="checkbox"/> Presumptive Disability	11B. <input type="checkbox"/> Impairment
DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED					
15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS BODY SYS. 01 CODE NO. 7160 Other and Unspecified Arthropathies		16B. SECONDARY DIAGNOSIS CODE NO. 3000 Anxiety Related Disorder/Functional Nonpsychotic	
17. DIARY TYPE MO/YR / REASON					
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/216(i)		19. CLAIMANT NOT DISABLED			
Not Disab. for Cash Bene. A. <input type="checkbox"/> Purp.		Disab. for Cash Benefit B. <input type="checkbox"/> Purp Beg.		Through Date of A. <input checked="" type="checkbox"/> Current Determination B. <input type="checkbox"/> Through Before Age 22 C. <input type="checkbox"/> (CDB only)	
20. VOCATIONAL BACKGROUND		OCC YRS.	ED YRS	21. VR ACTION A. <input type="checkbox"/>	SC IN B. <input type="checkbox"/>
22. REG-BASIS CODE J1		23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input checked="" type="checkbox"/>	25A. Initial A. <input type="checkbox"/>
26. LIST NO. <input type="checkbox"/>		A.	B.	C.	D.
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4 <input type="checkbox"/> Check if Vocational Rule Met. Cite Rule <input type="checkbox"/>					
28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Etab Beg. AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term					
29. LTR/PAR NO. Y		30. DISABILITY EXAMINER-DDS A OSSENFORT		31. DATE 12/17/19	
		32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) S NARODITSKY		32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE RFC1 in DDE 12/13/2019	
				33. DATE 32B. SPEC. CODE 19	
34. REMARKS RECON AFFIRMATION Sufficient evidence to support the RFC at step 5; NON-ATTORNEY REPRESENTATIVE: JONATHAN PFOSTER 303 SOUTH KEYSTONE AVE SAYRE PA 18840-1525				MULTIPLE IMPAIRMENTS CONSIDERED 34A. COMBINED MULTIPLE NONSEVERE-SEVERE 34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE	
35. BASIS CODE		36. REV.DET. CODES		37. SSA REPRESENTATIVE	
				SSA CODE	
				38. DATE	

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Disapproved Claim

Jennifer L. Brown
14 Main St Lot 429
Wellsburg, NY 14894

Date: September 20, 2019
Claim Number: 132-58-2507

We are writing about your claim for Social Security disability benefits. Based on a review of your health problems, you do not qualify for benefits on this claim. This is because you are not disabled under our rules.

The Decision on your Case

We've enclosed a page that gives you more details on how we made the decision on your claim.

About the Decision

The trained staff who looked at this case work for the State but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in this case.

The Disability Rules

You must meet certain rules to qualify for disabled worker's Social Security benefits. You must have the required work credits and your health problems must:

- keep you from doing any kind of substantial work (described below), and
- last, or be expected to last, at least 12 months in a row, or result in death.

Information about Substantial Work

Generally, substantial work is physical or mental work a person is paid to do. Work can be substantial even if it is part-time. To decide if a person's work is substantial, we consider the nature of the job duties, the skills and experience needed to do the job, and how much the person actually earns.

Usually, we find that work is substantial if gross earnings average over \$1220 per month after we deduct allowable amounts. This monthly amount is higher for Social Security disability benefits due to blindness.

See Next Page

A person's work may be different than before his/her health problems began. It may not be as hard to do and the pay may be less. However, we may still find that the work is substantial under our rules.

If a person is self employed, we consider the kind and value of his/her work, including his/her part in the management of the business, as well as income, to decide if the work is substantial.

Other Benefits

Based on the applications you filed, you are not entitled to any other benefits besides those you may already be getting. In the future, if you think you may be entitled to benefits, you will need to file again.

If You Disagree with the Decision

If you disagree with the decision, you have the right to appeal. A person who has not seen your case before will look at it. That person will review your case again and consider any new facts you have before deciding your case.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help. Or you may complete this form online at <http://www.socialsecurity.gov/disability/appeal>. Contact one of our offices if you want help.
- In addition, you should complete a "Disability Report-Appeal" to tell us about your medical condition since you filed your claim. You may complete this report online after you complete the online Request for Reconsideration. Or, you may contact one of our offices or call 1-800-772-1213.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing a decision. If you disagree with this decision and you file a new application instead of appealing:

- you might lose some benefits, or not qualify for any benefits, and
- we could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should ask for an appeal within 60 days.

If You Want Help with Your Appeal

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also other lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we withhold up to 25 percent of any past due Social Security benefits to pay toward the fee.

See Next Page

Family Benefits

If you have a spouse or child we cannot pay their benefits unless you are entitled to Social Security benefits.

If You Have Any Questions

We invite you to visit our website at www.socialsecurity.gov to find general information about Social Security. If you have any questions, call us toll free at 1-800-772-1213 or call your local Social Security office at 866-964-1715 . We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

District Office 114
SOCIAL SECURITY ADMIN
3345 CHAMBERS RD
SUITE 19
HORSEHEADS, NY 14845.

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

¿Sospecha que alguien está cometiendo fraude contra el Seguro Social?

Si sospecha de fraude contra el Seguro Social, por favor visite <http://oig.ssa.gov/e> o llame a la línea directa de abuso y fraude de la Oficina del Inspector General, 1-800-269-0271, y oprima el 7 para español (TTY 1-866-501-2101).

Social Security Administration

Enclosure:

Explanation of Determination

EXPLANATION OF DETERMINATION

Name of Claimant	W/E's Name (If CDB or DWB)	SSN	Type of Claim
Jennifer L. Brown		132-58-2507	DIB

The determination on your claim was made by a State agency based on Social Security law and regulation. It was NOT made by your own doctor or by other people or agencies providing reports about your condition. Any reports given us, however, were used in making this decision.

The State agency that decided your claim had the following: Robert Packer Hospital, report for the period of 05/26/18-06/26/19; James Freeman MD, report for the period of 12/12/08-07/20/19; Michael Gillan DO, report for the period of 04/16/13-04/18/19; Guthrie Health Systems, report of 06/27/19; Industrial Medicine Assoc PC, examination reports of 08/21/19. We did not obtain any other reports because no other reports were available.

We have determined that your condition is not expected to remain severe enough for 12 months in a row to keep you from working. In deciding this, we considered the medical evidence, your statements and how your condition affected your ability to work.

You said you were disabled because of Rheumatoid Arthritis, Chron's Disease, Anxiety, and Depression. The medical evidence shows that you have had pain and stiffness with some restriction of your activities. The reports did not show any conditions of a nature that within a year of 06/19/19 is expected to prevent you from working. We realize that at present you are unable to perform certain kinds of work. But based on your age of 42 years, your education of 14 years, and your experience, within a year it is expected you will be able to perform light work (for example, you could lift a maximum of 20 lbs., with frequent lifting or carrying of objects weighing up to 10 lbs., or walk or stand for much of the working day).

If your condition does not improve as expected, write, call or visit any Social Security office.

FORM SSA-4268-C4

Social Security Administration

Please read the instructions before completing this form.

OMB No. 0960-0527

EXHIBIT NO. B2B

PAGE 1 OF 5

Name (Claimant) (Print or Type) <u>Jennifer Lyn Brown</u>	Social Security Number <u>132-58-2507</u>
Wage Earner (If Different)	Social Security Number

Part I

CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this individual, Jonathan P. Foster, Jr., 303 South Keystone Avenue Sayce, PA 18840
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

(Name of Principal Representative)

Signature (Claimant) <u>Jennifer Lyn Brown</u>	Address <u>14 Main Street Lot 429</u> <u>Wellsburg, NY 14894</u>
Telephone Number (with Area Code) <u>1-07-215-0584</u>	Fax Number (with Area Code) Date <u>10-17-19</u>

Part II

REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Jonathan P. Foster, Jr., Esquire hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative) <u>[Signature]</u>	Address <u>303 South Keystone Avenue</u> <u>Sayce, PA 18840</u>
Telephone Number (with Area Code) <u>570-888-1529</u>	Fax Number (with Area Code) Date <u>570-882-8005</u> <u>10-17-19</u>

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

- ☒ I am charging a fee and requesting direct payment of the fee from withheld past-due benefits. (SSA must authorize the fee unless a regulatory exception applies.)
- ☐ I am charging a fee but waiving direct payment of the fee from withheld past-due benefits—I do not qualify for or do not request direct payment. (SSA must authorize the fee unless a regulatory exception applies.)
- ☐ I am waiving fees and expenses from the claimant and any auxiliary beneficiaries—By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)
- ☐ I am waiving fees from any source—I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative) [Signature] Date 10-17-19

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Choosing to be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, in the section titled "Information for Claimants."

Privacy Act Statement Collection and Use of Personal Information

Sections 206(a) and 1631(d) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on this form to verify your appointment of an individual as your representative and his or her acceptance of the appointment. Furnishing us this information is voluntary. However, if you want to use this form to appoint someone to act on your behalf in matters before the Social Security Administration (SSA), then you and that individual must complete the appropriate sections of this form. We rarely use the information you supply for any purpose other than to verify your appointment of an individual as your representative and his or her acceptance of the appointment. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice entitled, Appointed Representative File, 60-0325. Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office. We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

How to Complete this Form

Please print or type your answers on this form. At the top of the form, provide your full name and your Social Security number. If your claim is based on another person's work and earnings, also provide the "wage earner's" name and Social Security number. If you appoint more than one individual as your representative, you may want to complete a form for each of them.

Part I Claimant's Appointment of Representative

Give the name and address of the individual(s) you are appointing. You may appoint an attorney or any other qualified individual to represent you. You also may appoint more than one individual, but please refer to the "Information for Claimants" section "What your Representative(s) May Charge" for more information about payment of fees. You can appoint one or more individuals in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns Supplemental Security Income.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.
- Title VIII (SVB), if your claim concerns entitlement to Special Veterans Benefits.

When you give your permission your representative may designate an associate (e.g. a clerk), or other party or entity (e.g. a copying service) to receive information from your claim file on your representative's behalf for the duration of your claim. If you want to give your representative permission to do that, check the block to authorize this release.

If you will have more than one representative, check the appropriate block and give the name of the individual you want to be your principal representative. SSA will make contacts with, and send notices or requests for development to, only the principal representative. The principal representative will provide copies of notices or requests to other co-representatives.

You must sign and date the form. Print or type your address, area code and telephone number.

If you are appointing a representative to replace a representative that you discharged or who withdrew his or her representation, you must notify us in writing that the prior appointment has ended.

Part II Representative's Acceptance of Appointment

Each individual you appoint in Part I should also complete Part II. If the individual is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part III Fee Arrangement

To help in processing benefits and fee payments timely you and your representative should complete this section. Your representative should check a box, sign and date the form. Your representative may choose to receive payment, waive direct payment, or waive payment of the fee altogether. If you and your representative change your arrangement before we decide your claim, you can provide a new or amended form so that we can update our records. If you appoint a second representative or co-counsel who also will not charge a fee, he or she should also complete this part or provide a new form, or if not using the form, give us a separate, written waiver statement. If your representative is not eligible for direct payment, or is an attorney or an eligible non-attorney who waives direct payment, you will be responsible for paying any fee we authorize.

Under certain circumstances, we do not have to authorize the fee. These circumstances include where a Court has awarded a fee based on your representative's actions as a legal guardian or court-appointed representative, or where a business (such as an insurance company), other organization or government agency will pay your representative's fee and you and your beneficiaries have no liability to pay any fees or expenses.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406 (a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 408.1101, and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Fees for Representation

An attorney or other individual who wants to charge or collect a fee for providing services in connection with a claim before the Social Security Administration (SSA) must generally obtain our prior authorization of the fee for representation. The only exceptions are if:

- certain requirements are met and a third-party entity, such as a business, an insurance carrier, a for profit, or nonprofit organization or a government agency will pay the fee and any expenses from its own funds and the claimant and auxiliary beneficiaries incur no liability, directly or indirectly, for the cost(s); or
- a Federal court awarded a fee based on the representative's activities as the claimant's legal guardian or court-appointed representative;
- a Federal court awarded a fee for representational services provided before the court. In those cases, neither the Federal court nor SSA can authorize a fee for the other.

Obtaining Authorization of a Fee

To charge a fee for services, you must use one of two mutually exclusive fee authorization processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we authorize.

Fee Petition Process

You may file a fee petition after you complete your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of the fee you are requesting. In order to directly pay you under a fee petition, you must either file a fee petition or notify us within 60 days after we decide the claim of your intent to file a fee petition.

You must give the claimant a copy of the fee petition and each attachment. The claimant may disagree with the information shown by contacting a Social Security office within 20 days of receiving his or her copy of the fee petition. We will consider the reasonable value of the services provided, and send you notice of the amount of the fee you can charge.

Fee Agreement Process

If you and the claimant have a written fee agreement, one of you must give it to us before we decide the claim(s). We usually will approve the agreement if:

- you both signed it;
- the fee you agreed on is no more than 25 percent of past-due benefits, or \$6,000 (or a higher amount we set and announce in the Federal Register), whichever is less;
- we approve the claim(s); and
- the claim results in past-due benefits.

We will send you a copy of the notice we send the claimant telling him or her the amount of the fee you can charge based on the agreement.

If we do not approve the fee agreement, we will tell you in writing. We also will tell you and the claimant that you must file a fee petition if you wish to charge and collect a fee.

After we tell you the amount of the fee you can charge, you or the claimant may ask us in writing to review the authorized fee. If we approved a fee agreement, the person who decided the claim(s) also may ask us to lower the amount. Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

Collecting a Fee

You may accept money for your fee in advance, as long as you hold it in a trust or escrow account. The claimant never owes you more than the fee we authorize, except for:

- any fee a Federal court allows for your services before it; and
- out-of-pocket expenses you incur or expect to incur, for example, the cost of getting evidence. Our authorization is not needed for such expenses.

If you are not an attorney and you are ineligible to receive direct payment, you must collect the authorized fee from the claimant. If you are interested in becoming eligible to receive direct payment, you can find more information about this on our "Representing Social Security Claimants" website:
<http://www.ssa.gov/representation/>.

If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you register with SSA, as described below, we usually withhold 25 percent of any past-due benefits that result from a favorably decided retirement, survivors, disability insurance, or supplemental security income claim. Once we authorize a fee, we pay you all or part of the fee from the funds withheld. We will also charge you the assessment required by section 206(d) and 1631(d)(2)(C) of the Social Security Act. You cannot charge or collect this expense from the claimant. You will need to collect from the claimant:

- **the rest of the fee he or she owes**, if the amount of the authorized fee is more than the amount of money we withheld and paid you for the claimant, plus any amount you held for the claimant in a trust or escrow account.
- **all of the fee he or she owes**, if we did not withhold past-due benefits, (for example, because there are no past-due benefits; you waived direct payment or did not register for direct payment; the claimant discharged you or you withdrew from representing before we issued a favorable decision); or we withheld past-due benefits, but you did not ask us to authorize a fee or tell us that you planned to ask for a fee within 60 days after the date of the notice of award and we released the withheld amount to the claimant.

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406(a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 408.1101, and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Registering for Direct Fee Payment

If you are eligible and want to receive direct payment, you must register with us before we effectuate a favorable decision on the claim. To register, you must submit a Form SSA-1699 (Registration of Individuals and Staff for Appointed Representative Services) once and a Form SSA-1695 (Identifying Information for Possible Direct Payment of Authorized Fees) with each appointment. We will use the information you provide on these forms to issue you a Form 1099-MISC if we pay you aggregate fees of \$600 or more in a calendar year. The Internal Revenue Code requires that we do this. For information on the registration process, see our "Representing Social Security Claimants" website <http://www.ssa.gov/representation/>.

Conflict of Interest and Penalties

If you commit improper acts, you can be suspended or disqualified from representing anyone before SSA. You also can face criminal prosecution. Improper acts include:

- If you are or were an officer or employee of the United States, providing services as a representative in certain claims against and other matters affecting the Federal government.
- Knowingly and willingly furnishing false information.
- Charging or collecting an unauthorized fee, or charging or collecting too much for services provided in any claim, including services before a court that made a favorable decision.

FOSTER LAW OFFICE
CONTINGENT FEE AGREEMENT AND FEE SCHEDULE
SOCIAL SECURITY CLAIMS

I, Jennifer Lyn Brown (SSN: 132-58-2507) do hereby appoint FOSTER LAW OFFICE to be my attorney to represent me in a claim for Social Security Disability Insurance Benefits (DIB) and/or Supplemental Security Income Benefits (SSI) under the provisions of the Social Security Act.

CONTINGENT FEE ON SSD/SSI CLAIMS

The undersigned Claimant and Attorney/Representative hereby agree to the payment of a representation fee in the matter of a claim for benefits payable to me and my auxiliary beneficiaries, spouse, and children before the Social Security Administration to the Attorney/Representative. Both parties understand and agree that amount of the fee shall not exceed the lesser of (25%) of past due benefits or Six Thousand (\$6,000.00) Dollars. Claimant has been informed that if he or she is found entitled to past due benefits, the Six Thousand (\$6,000.00) Dollar limit is subject to adjustments for inflation by the Social Security Administration under 42 USC 406 (a)(2)(A), and the limit in effect at the time the client is paid shall be the limit under this contract. The Social Security Administration will notify him or her and the Attorney/Representative, in writing, of the amount of past due benefits and the maximum fee that may be charged.

I understand that any fee charged by FOSTER LAW OFFICE is subject to approval by an official of the Social Security Administration or a Federal Court Judge.

In the event there is an appeal of an Unfavorable Decision to the Appeals Council and/or to the Federal Court the Fee Agreement shall be 25% of all past due benefits with no limitation of the amount of the fee subject to Court approval.

COSTS

In addition, I understand that if FOSTER LAW OFFICE had advanced any costs on my behalf, I will be required to reimburse FOSTER LAW OFFICE for any advanced costs in addition to any attorneys fee that is paid to FOSTER LAW OFFICE

FEES ON CONTINUING DISABILITY REVIEW/CESSATION CLAIMS

I understand that if I am currently receiving benefits, I will forward twenty-five (25%) percent of my monthly check to FOSTER LAW OFFICE to be placed in escrow pending fee approval. Funds in escrow will not exceed six thousand (\$6,000.00) dollars.

REPRESENTATION ON APPEAL/FIRM WITHDRAWAL

In the event of an unfavorable result either partially or wholly, FOSTER LAW OFFICE is not obligated to file an appeal on behalf of the client.

FOSTER LAW OFFICE also retains the right to withdraw from the representation of my claim in this matter at any time for any reason whatsoever, upon reasonable written notice to me.

Claimant certifies that the Attorney/Representative has explained to him or her fee amounts allowed by the Social Security Administration, and knowingly consents to the award of fee in accordance with the statements set forth herein.

Dated: 10/17/19

JONATHAN P. FOSTER, JR.

JONATHAN P. FOSTER, SR.

Jennifer Lyn Brown
Client

[Signature]
Attorney

[Signature]
Attorney

[illegible]

Social Security Notice of Reconsideration

Jennifer L. Brown
14 Main St Lot 429
Wellsburg, NY 14894

Date: January 22, 2020
Claim Number: 132-58-2507

Upon receipt of your request for reconsideration, we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your claim has been thoroughly evaluated; this includes the medical evidence and additional information received since the original decision. We find that the previous determination was proper under the law. The second page of this notice identifies the legal requirements for your type of claim.

The determination on your claim was made by an agency of the State. It was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination. Doctors and other people in the State Agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

If you believe that the reconsideration determination is not correct, you may request a hearing before an Administrative Law Judge of the Office of Disability Adjudication Review. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or file your appeal on line at <http://www.socialsecurity.gov/disability/appeal>. Read the enclosed leaflet for a full explanation of your right to appeal.

New Application:

You have the right to file a new application at the time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing;

- You might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision you should file an appeal within 60 days.

This decision refers only to your claim for benefits under the Social Security Disability Insurance Program. If you applied for other benefits, you will receive a separate notice when a decision is made on that claim(s).

If you have questions about your claim, you should get in touch with any Social Security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this letter with you.

See Next Page

Copy sent to: Jonathan Pfoster

Requirements for Disability Benefits

Disability Insurance Benefits

To be considered disabled, a person must be unable to do any substantial gainful work due to a medical condition which has lasted or is expected to last for at least 12 months in a row. The condition must be severe enough to keep a person from working not only in his or her usual job, but also in any other substantial gainful work. We look at the person's age, education, training and work experience when we decide whether he or she can work.

Disabled Widow or Widower Benefits

A widow, widower or surviving divorced spouse (age 50 to 60) must meet the disability requirement of the law within a specified 7-year period. A person may be considered disabled only if he or she has a physical or mental impairment which has lasted or is expected to last for at least 12 months in a row. The condition must be severe enough to keep a person from working not only in his or her usual job, but also in any other substantial gainful work. We look at the person's age, education, training and work experience when we decide whether he or she can work.

Childhood Disability Benefits

Childhood disability benefits may be paid to a person age 18 or older if the person has a disability which began before age 22 or within 84 months of the end of an earlier period of childhood disability. A person may be considered disabled only if he or she has a physical or mental impairment which has lasted or is expected to last for at least 12 months in a row. The condition must be severe enough to keep a person from working not only in his or her usual job, but also in any other substantial gainful work. We look at the person's age, education, training and work experience when we decide whether he or she can work.

If you are still not satisfied with the decision:

You may request a hearing of this decision by the Office of Disability Adjudication Review. **YOU MUST REQUEST THE HEARING WITHIN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE.** If you cannot send us a written request for a hearing within 60 days, be sure to contact us by phone or online. If you wait longer than 60 days, we will not conduct a hearing review of our decision unless you have a good reason for the delay.

If you request a hearing, your case will be assigned to an administrative law judge at the Office of Disability Adjudication Review. The Administrative Law Judge will let you know when and where your case will be heard.

The hearing proceedings are informal. The Administrative Law Judge will summarize the facts in your case, explain the law, and state what must be decided. Then you will have an opportunity to explain why you disagree with the decision made in your case, to present additional evidence and to have witnesses testify for you. You can also request the Administrative Law Judge to subpoena unwilling witnesses to appear for cross-examination and to bring with them any information about your case. You have the right to request the administrative law judge to issue a decision based on the written record without you personally appearing before him/her. If you decide not to appear at the hearing you still have the right to submit additional evidence. The Administrative Law Judge will base the decision on the evidence in your file plus any new evidence submitted.

In having your case heard, you can represent yourself or be represented by a lawyer, a friend, or any other person. Contact your Social Security office for names of organizations that can help you.

If You Have Any Questions

We invite you to visit our website at www.socialsecurity.gov to find general information about Social Security. If you have any questions, call us toll free at 1-800-772-1213. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. We can answer most questions over the phone. You can also write or visit any Social Security office.

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

¿Sospecha que alguien está cometiendo fraude contra el Seguro Social?

Si sospecha de fraude contra el Seguro Social, por favor visite <http://oig.ssa.gov/e> o llame a la línea directa de abuso y fraude de la Oficina del Inspector General, 1-800-269-0271, y oprima el 7 para español (TTY 1-866-501-2101).

Social Security Administration

Enclosure:
Explanation of Determination

EXPLANATION OF DETERMINATION

Name of Claimant	W/E's Name (If CDB or DWB)	SSN	Type of Claim
Jennifer L. Brown		132-58-2507	DIB

The determination on your claim was made by a State agency based on Social Security law and regulation. It was NOT made by your own doctor or by other people or agencies providing reports about your condition. Any reports given us, however, were used in making this decision.

The State agency that decided your claim had the following in addition to the report(s) mentioned in our last notice: Guthrie Clinic, report for the period of 07/08/16-08/30/19. We did not obtain any other reports because no other reports were available.

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You said you were disabled because of an emotional problem, arthritis, and pain and stiffness with some restriction of your activities. The medical evidence shows that you have had an emotional problem, arthritis, and pain and stiffness with some restriction of your activities. The reports did not show any conditions of a nature that would prevent you from working. We realize that at present you are unable to perform certain kinds of work. But based on your age of 43 years, your education of 14 years, and your experience, you can perform light work (for example, you could lift a maximum of 20 lbs., with frequent lifting or carrying of objects weighing up to 10 lbs., or walk or stand for much of the working day).

We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

Social Security Notice of Reconsideration

Jonathan Pfoster
303 South Keystone Ave
Sayre, PA 188401525

Date: January 22, 2020
Claim Number: 132-58-2507
Claimant Name: Jennifer L. Brown

Upon receipt of your request for reconsideration, we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your claim has been thoroughly evaluated; this includes the medical evidence and additional information received since the original decision. We find that the previous determination was proper under the law. The second page of this notice identifies the legal requirements for your type of claim.

The determination on your claim was made by an agency of the State. It was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination. Doctors and other people in the State Agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

If you believe that the reconsideration determination is not correct, you may request a hearing before an Administrative Law Judge of the Office of Disability Adjudication Review. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or file your appeal on line at <http://www.socialsecurity.gov/disability/appeal>. Read the enclosed leaflet for a full explanation of your right to appeal.

New Application:

You have the right to file a new application at the time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing;

- You might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision you should file an appeal within 60 days.

This decision refers only to your claim for benefits under the Social Security Disability Insurance Program. If you applied for other benefits, you will receive a separate notice when a decision is made on that claim(s).

If you have questions about your claim, you should get in touch with any Social Security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this letter with you.

See Next Page

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If you are still not satisfied with the decision:

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In having your case heard, you can represent yourself or be represented by a lawyer, a friend, or any other person. Contact your Social Security office for names of organizations that can help you.

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If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

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Jennifer L. Brown		132-58-2507	DIB

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We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.


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February 27, 2020, 07:31

PAGE 2

NH 132-58-2507

PREVENT ME FROM WORKING AND RESTRICT MY ACTIVITIES.

I AM REPRESENTED BY JONATHAN P FOSTER JR, WHO IS AN ATTORNEY.

MY PHONE NUMBER IS 607-215-0584.

DATE February 26, 2020.

**SOCIAL SECURITY ADMINISTRATION****Refer To:**

Jennifer Lyn Brown

Office of Hearings Operations

SSA OHO HEARING OFC

5TH FLOOR

300 S STATE ST

SYRACUSE, NY 13202-9916

Tel: 888-655-6477

Fax: 315-479-3933

March 05, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Dear Jennifer Lyn Brown:

Thank you for your request for a hearing. We will mail a Notice of Hearing to you at least 75 days before the date of your hearing to tell you its time and place. Although we will make every effort to schedule your hearing as soon as possible, there may be a delay. If you wish to discuss the status of your case, you may call us or write to us. Our telephone number and address are at the top of this page.

We are required by the district court opinion dated May 28, 1985 in *Martinez, et al. v. Secretary of HHS*, E.D.N.Y., No. 73 Civ. 900, to notify you of procedures available to you in the event of unreasonable delay in processing your case. If, after requesting the status of your case, you believe your case is being delayed unreasonably, you may apply to the United States District Court for relief, including interim benefits.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) **Please let us know by completing and returning the attached form in the envelope we sent your representative.** We will arrange for you to appear in person.

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

Suspect Social Security Fraud? Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Form HA-L2 (04-2015) **127**

Representative

See Next Page

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Your Right to An Interpreter At Your Hearing

You are not required to bring an interpreter. You **must** request an interpreter so we can provide an interpreter **free of charge**. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. You must inform us about or give us evidence no later than five business days before the date of your hearing. The ALJ may choose to not consider the evidence if you fail to provide it timely.

We can help you get evidence. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence in Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Sincerely yours,

Mary Jane Pelton
Hearing Office Director

Enclosures:

HA-55 (Objection to Appearing by Video Teleconferencing)
Form SSA-L1697-U3 (Acknowledgement of Representation)
HA-L4 (What Happens Next)
SSA Publication No. 70-067 (Why You Should Have Your Hearing By Video)
HA-827 (Medical Release Notice)
SSA-827 (Authorization to Disclose Information to SSA)
Form HA-L32 (Electronic Disability Claims Processing Insert)
Barcode Sheet

cc: Jonathan P Foster, Jr
303 S. Keystone Ave
Sayre, PA 18840

**SOCIAL SECURITY ADMINISTRATION****Refer To:**

Jennifer Lyn Brown

Office of Hearings Operations

SSA OHO HEARING OFC

5TH FLOOR

300 S STATE ST

SYRACUSE, NY 13202-9916

Tel: 888-655-6477

Fax: 315-479-3933

March 05, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Dear Jennifer Lyn Brown:

Thank you for your request for a hearing. We will mail a Notice of Hearing to you at least 75 days before the date of your hearing to tell you its time and place. Although we will make every effort to schedule your hearing as soon as possible, there may be a delay. If you wish to discuss the status of your case, you may call us or write to us. Our telephone number and address are at the top of this page.

We are required by the district court opinion dated May 28, 1985 in *Martinez, et al. v. Secretary of HHS*, E.D.N.Y., No. 73 Civ. 900, to notify you of procedures available to you in the event of unreasonable delay in processing your case. If, after requesting the status of your case, you believe your case is being delayed unreasonably, you may apply to the United States District Court for relief, including interim benefits.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) **Please let us know by completing and returning the attached form in the envelope we sent your representative.** We will arrange for you to appear in person.

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

Suspect Social Security Fraud? Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Form HA-L2 (04-2015) **130**

Claimant

See Next Page

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Your Right to An Interpreter At Your Hearing

You are not required to bring an interpreter. You **must** request an interpreter so we can provide an interpreter **free of charge**. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. You must inform us about or give us evidence no later than five business days before the date of your hearing. The ALJ may choose to not consider the evidence if you fail to provide it timely.

We can help you get evidence. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence in Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Jennifer Lyn Brown

EXHIBIT NO. B7B
PAGE: 6 OF 15

Sincerely yours,

Mary Jane Pelton
Hearing Office Director

Enclosures:

HA-55 (Objection to Appearing by Video Teleconferencing)
HA-L4 (What Happens Next)
SSA Publication No. 70-067 (Why You Should Have Your Hearing By Video)
HA-827 (Medical Release Notice)
SSA-827 (Authorization to Disclose Information to SSA)

cc: Jonathan P Foster, Jr
303 S. Keystone Ave
Sayre, PA 18840

Social Security Administration

OBJECTION TO APPEARING BY VIDEO TELECONFERENCING

Name: Jennifer Lyn Brown

Social Security Number: 132-58-2507

Wage Earner:

Hearing Office: Syracuse

RQID:000000000000000000000000273092516 SITE:X02 DR:S
SSN:132582507 DOCTYPE:3267 RF:D CS:d970

[] I do not want to appear at my hearing by video teleconference. Please schedule my hearing so that I may appear in person. I understand that by objecting to appearing by video teleconference I may experience a delay in my hearing.

Please return this form only if you object to a hearing by video teleconference.

Additional Comments: _____

Signature:

Date:

Area Code and Telephone Number:

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you are opting-out of an appearance via video teleconferencing. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**SOCIAL SECURITY HEARING PROCESS
WHAT HAPPENS NEXT?**

- * Your hearing request and your file are now at the Office of Hearings Operations (OHO).
- * We may look at your case to see if we can make a decision in your favor without a hearing. If we do not make a decision this way, we will prepare your case for an administrative law judge (ALJ). We prepare cases in the order we get them.
- * An ALJ will review your file after we prepare it. We will then schedule a hearing for your case. You will get a notice informing you when and where we will hold your hearing. We will send you the notice at least 75 days before the date of your hearing. If you have a representative, we will also send the notice to that person.
- * You will come to your hearing and talk to the ALJ. Other people, such as witnesses or your representative, can also come to your hearing. If the ALJ wants any more evidence, or if you ask for more time to give us more evidence, the ALJ will tell you how long we will wait for that evidence.
- * The ALJ will make a decision after your hearing if he or she has all of the evidence. Otherwise, the ALJ will make a decision when he or she gets the evidence needed to make a decision.
- * You can expect to wait another 3 months after the hearing until you receive your written decision in the mail.
- * We cannot talk to you about the outcome of your case before we mail you the written decision.
- * Remember: In order to make your case go as quickly as possible, please be sure to send us all of your medical and other evidence as soon as possible. Your representative, if you have one, may also send evidence to us. Having the evidence sooner could help the ALJ decide your case sooner.



Your Guide to Social Security Disability Video Hearings

When you request a hearing with the Office of Hearings Operations (OHO) at the Social Security Administration (SSA), we will hold your hearing by video teleconference, in-person, or, in extraordinary circumstances, by telephone.

What is a Video Hearing

- Video hearings are just like in-person hearings, except that you and anyone who comes to the hearing with you, such as your representative or witnesses, will view, listen, and speak to an Administrative Law Judge (ALJ) in a different location by using a video monitor.
- We may schedule you to appear by video unless you object to appearing by video within 30 days after you receive a letter from us that acknowledges your request for a hearing.
- We process and conduct in-person and video hearings in the same way. There are a number of advantages to a video hearing, as opposed to an in-person hearing, including the following:
 - Greater Convenience and Flexibility** – Our network of video hearing locations continues to grow. Video hearing locations may be closer to you than one of our hearing offices.
 - Possibility of a quicker hearing** – Often, we can schedule a video hearing faster than an in-person hearing. You will have access to more locations and more ALJs, which makes it easier to schedule your hearing.

How Does a Video Hearing Work?

- We will send you a notice that tells you the **time and place** for your hearing at least 75 days before your scheduled hearing date. Pay special attention to the place/address, as it may be different from where your case was handled previously.
- If you have a representative, witnesses, or both, they can appear with you at the video hearing location.
- On the date of your hearing, the video hearing location could be an OHO hearing office, your representative's office, or a SSA field office. You should arrive at least 30 minutes before the scheduled time of your hearing.
- A video hearing uses state-of-the-art equipment that allows you and the ALJ to see, hear, and speak to each other in real time, just as if you were talking face to face.
- Transmission of the hearing is secure, and we protect your privacy. Just like in-person hearings, we record only the audio portion of video hearings. We do not record the video portion of any of our hearings.
- A technician will be available to make sure the video teleconferencing equipment is connected and working properly.



Help Us to Serve You Better! If you do not show up on the date of your scheduled hearing, your request for hearing may be dismissed. You must tell us in writing as soon as you realize you cannot appear at the time and place shown on your hearing notice. Unless the ALJ pre-approves your request to change the time or place of your hearing, you should appear. By letting us know you cannot appear, you give another person the opportunity to use that hearing slot for his or her hearing.

**NOTICE TO REPRESENTATIVE OF CLAIMANT BEFORE
THE SOCIAL SECURITY ADMINISTRATION**

TOE 420

Jonathan P Foster, Jr
303 S. Keystone Ave
Sayre, PA 18840Date: March 02, 2020
Claimant: Jennifer Lyn Brown
Wage Earner:
Social Security Number: 132-58-2507

We have received written notice that the claimant has appointed you to act as the representative in connection with this claim(s) under the Social Security Act (the Act). We will, therefore, be dealing directly with you on matters pertaining to this claim(s).

Generally, to charge a fee for services, you must use one of two, mutually exclusive fee approval processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we approve.

Fee Petition Process

You may ask for approval of a fee by giving us a fee petition when you have completed your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of fee you are requesting.

Fee Agreement Process

If you and the claimant have a written fee agreement, that you have not already submitted, either of you must give it to us before we decide the claim(s). We usually will approve the agreement if you both sign it; the fee you agreed on is no more than 25 percent of the past-due benefits, or \$6,000 (or a higher amount we set and announce in the Federal Register), whichever is less; we approve the claim(s); and the claim results in past-due benefits.

If you do not file a fee agreement, you must use form **SSA-1560-U5 (PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION)** to petition for approval of the fee you wish to charge. File the SSA-1560-U5 when the proceedings are complete and your services have ended. If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you seek direct payment from the claimant's title II or title XVI past-due benefits, you must file the SSA-1560-U5, or a notice of intent to petition for a fee within 60 days of the notice of the favorable determination. Further information and instructions for completion are given on the form itself.

After we approve a fee, you must look to the claimant for payment, except when you are an attorney or non-attorney who is eligible to receive direct payment and there are past-due benefits payable under title II or title XVI of the Act as a result of a favorable determination on the claim. In such cases, we will pay up to 25 percent of such past-due benefits directly to you toward payment of the approved fee and charge you the assessment required by section 206(d) and 1631(2)(2)(c) of the Social Security Act. You cannot charge or collect this expense from the claimant.

If you wish to waive either a fee or direct payment of a fee and you have not already done so, you should sign and date the appropriate box below or send us a letter with an appropriate statement. Early filing of the waiver will enable us to prevent the automatic withholding of past-due benefits for a possible direct payment.

• **WAIVER OF FEE** - I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligation, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)

Date

• **WAIVER OF DIRECT PAYMENT BY ATTORNEY OR NON-ATTORNEY ELIGIBLE TO RECEIVE DIRECT PAYMENT** - I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative)

Date

Social Security Administration

Form **SSA-L1697-U3 (2-2005)**
Destroy Prior Editions

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

Your client's case is available to be viewed electronically using the Appointed Representative Services (ARS). If you do not already have access to ARS, please contact your local hearing office to initiate the registration process. Once you have access, your client's case will be viewable at <https://secure.ssa.gov/acu/LoginWeb/>.

NOTE: If you are requesting direct payment of the authorized fee, you must access your clients' files electronically using ARS.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the notice. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- o **Send the evidence using the Eletronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.**
- o **Fax the evidence using this fax number -- (877)304-5049. Remember that the enclosed barcode must be the first page for each document being faxed.**
- o **Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**

SYRACUSE, NY OHO

P. O. BOX 9045

LONDON, KY 40742-9045

You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Bar codes may be used more than once when faxing evidence into the electronic file.



SOCIAL SECURITY ADMINISTRATION

Refer To:

Jennifer Lyn Brown

Office of Hearings Operations
SSA OHO HEARING OFC
5TH FLOOR
300 S STATE ST
SYRACUSE, NY 13202-9916
Tel: 888-655-6477
Fax: 315-479-3933

March 05, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Dear Jennifer Lyn Brown:

In order to obtain records to update your file we need a current Authorization to Release Information. Please sign the enclosed form(s) and return it to our office within ten (10) days. A return envelope is enclosed for your convenience.

Sincerely yours,

Mary Jane Pelton
Hearing Office Director

cc: Jonathan P Foster, Jr
303 S. Keystone Ave
Sayre, PA 18840

Enclosure (SSA-827)

Form Approved
OMB No. 0960-0623**WHOSE Records to be Disclosed**

NAME (First, Middle, Last, Suffix)

Jennifer Lyn Brown

SSN

132-58-2507

Birthday (mm/dd/yy)

10/26/1976

**AUTHORIZATION TO DISCLOSE INFORMATION TO
THE SOCIAL SECURITY ADMINISTRATION (SSA)****** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ******I voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange):**OF WHAT** All my medical records; also education records and other information related to my ability to perform tasks.
This includes specific permission to release:**1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**

- Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
- Gene-related impairments (including genetic test results)

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.****4. Information created within 12 months after the date this authorization is signed, as well as past information.****FROM WHOM**

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**TO WHOM****The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]**PURPOSE**Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure**SIGN >>****IF not signed by subject of disclosure, specify basis for authority to sign**☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign

here if two signatures required by State law) >>

Date Signed

Street Address

14 Main St. Lot 429

Phone Number (with area code)

607-215-0584

City

Wellsburg

State

NY

ZIP

14894

WITNESS I know the person signing this form or am satisfied of this person's identity:**SIGN >>****IF needed, second witness sign here (e.g., if signed with "X" above)**
SIGN >>

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory **or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*



**Please include this barcode cover sheet as the first page
of each set of documents returned.**

877-304-5049



SSN: 132-58-2507

Form **HA-510** (01-2020) UF
Discontinue Prior Editions
Social Security Administration

Page 1 of 2
OMB No.0960-0671

Waiver of Timely Written Notice of Hearing

In the case of:
Jennifer Lyn Brown
(Claimant)

Claim for:
Period of Disability and Disability Insurance Benefits

(Wage Earner)(Leave blank if same as above)

132-58-2507

(Social Security Number)

Under 20 CFR 404.938 and/or 20 CFR 416.1438, where applicable, I am entitled to receive a 75 day advance written notice of the hearing in my case. Having been fully advised of such right, I hereby waive the 75 day advance notice requirement.

(Signature)

(Street Address)

(City, State, and Zip Code)

(Area Code and Telephone Number)

Date: _____

Form HA-510 (07-2017) UF

Page 2 of 2

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(b)(1), 205(d), and 1631(c) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from completing the hearing process.

We will use the information to document your waiver of rights to receive the written Notice of Hearing. We may also share your information for the following purposes, called routine uses:

1. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and
2. To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for the SSA as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form HA-510 (01-2020) UF
Discontinue Prior Editions
Social Security Administration

Page 1 of 2
OMB No.0960-0671

Waiver of Timely Written Notice of Hearing

In the case of;
Jennifer Lyn Brown
(Claimant)

Claim for:
Period of Disability and Disability Insurance Benefits

(Wage Earner)(Leave blank if same as above)

132-58-2507
(Social Security Number)

Under 20 CFR 404.938 and/or 20 CFR 416.1438, where applicable, I am entitled to receive a 75 day advance written notice of the hearing in my case. Having been fully advised of such right, I hereby waive the 75 day advance notice requirement.

Jennifer Lyn Brown
(Signature)
14 main St. Lot 429
(Street Address)
Wellsburg, NY 14894
(City, State and Zip Code)
(607) 215-0584
(Area Code and Telephone Number)

Date: June 23, 2020

Office of Disability
Adjudication
JUN 25 2020
SYRACUSE
NEW YORK



Form HA-510 (07-2017) UF

Page 2 of 2

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(b)(1), 205(d), and 1631(c) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from completing the hearing process.

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SOCIAL SECURITY ADMINISTRATION

Refer To:
Jennifer Lyn Brown

Office of Hearings Operations
5th Floor
300 S State St
Syracuse, NY 13202-9916
Tel: (888)655-6477 / Fax: (833)779-0462

June 29, 2020

Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

NOTICE OF HEARING

I have scheduled your hearing for:

Day: Wednesday **Date:** July 22, 2020 **Time:** 11:30 AM
Eastern (ET)

I will conduct your hearing by telephone because it is not possible for you to attend in person or by video teleconferencing, or other extraordinary circumstances prevent you from attending in person or by video teleconferencing. On the date and at the time listed above, I will call you at the telephone number in our file. The number is (607)215-0584. If this is not the correct telephone number, please call this office immediately.

It Is Important That You Attend Your Hearing

I have set aside this time for you to tell me about your case. If you do not attend the hearing and I do not find that you have a good reason, I may **dismiss** your request for hearing. I may do so without giving you further notice.

Complete the Enclosed Form

Please complete and return the enclosed acknowledgement form at the earliest possible opportunity. Please use the enclosed envelope to return the form to us. We sent your representative a copy of the acknowledgment form. Your representative also should return his or her copy of the form.

Form HA-83 (04-2015)
Representative

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline
at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

Jennifer Lyn Brown (132-58-2507)

Page 2 of 5

If You Cannot Attend Your Scheduled Hearing

If you are not able to attend your hearing at the time we have set, please call this office immediately.

If you wish to change the time of your hearing, you must ask for a change. Your request must be in writing to tell me why you need the change and the time you would like the hearing held.

You must ask for this change before the earlier of the two dates described below. The first date is 30 days after you receive this notice. The second date is 5 days before the date of your hearing. We assume you received this notice 5 days after the date on it unless you show us that you did not get it within the 5-day period. If you delay in asking for a change, I will also decide whether you have a good reason for the delay. I will rule on your request based on our standards for deciding if there is a good reason for changing the time and place of your hearing.

I will decide whether you have a good reason for requesting the change. If I find you have a good reason for your request, we will set a new time for your hearing. We will also send another notice giving you the new time of your hearing. We will send this notice at least 20 days before the date of the new hearing.

Submitting More Evidence and Reviewing Your File

You are required to inform us about or submit all evidence known to you that relates whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. **If you are aware of or have more evidence, such as recent records, reports, or evaluations, you must inform me about it or give it to me no later than 5 business days before the date of your hearing. If you do not comply with this requirement, I may decline to consider the evidence unless the late submission falls within a limited exception.**

If you missed the deadline to inform us about or submit evidence, I will accept the evidence if I have not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

1. Our action misled you;
2. You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier, or;
3. Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier.

If you want to see your file before the date of your hearing, please call this office and make arrangements. If your file is electronic, you may ask for a copy on a compact disc.

Jennifer Lyn Brown (132-58-2507)

Page 3 of 5

Issues I Will Consider

The hearing concerns your application of June 19, 2019, for a Period of Disability and Disability Insurance Benefits under sections 216(i) and 223(a) of the Social Security Act (the Act). I will consider whether you are disabled under sections 216(i) and 223(d) of the Act.

Under the Act, I will find you disabled if you have a physical or mental condition(s) that:

- Keeps you from doing any substantial gainful work; **and**
- Has lasted 12 straight months, can be expected to last for 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide whether you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

- Any work you have done after your condition(s) began;
- The severity of your condition(s);
- Whether you can do the kind of work you did in the past; and
- Whether you can do any other kind of work considering your age, education, and work experience.

I will also consider whether you have enough earnings under Social Security to be insured for a Period of Disability and Disability Insurance Benefits. If you do, I must decide whether you became disabled while you were insured.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 404, Subpart B and Subpart P.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

If I find that you are disabled and that you have a substance use disorder (drug, alcohol, or both), I also will decide whether it is a contributing factor material to the determination of disability. This means I will decide whether you would be disabled if you were not using drugs or alcohol. If drug addiction or alcoholism is a contributing factor material to the determination of your disability, I will find you not disabled under Sections 223(d)(2), or 1614(a)(3), or 223(d)(2) and 1614(a)(3) of the Social Security Act.

Jennifer Lyn Brown (132-58-2507)

Page 4 of 5

Remarks

A vocational expert will appear at the hearing by telephone.

If You Object to the Issues

If you object to the issues or remarks listed above, you must tell me in writing why you object. You must tell me as soon as possible before the hearing, but not later than 5 business days before the date of the hearing. You must state the reason(s) for your objection.

Your Right To Request a Subpoena

I may issue a subpoena that requires a person to submit documents or testify at your hearing. I will do this if the person has evidence or information that you reasonably need to present your case fully.

If you want me to issue a subpoena, you must write to me as soon as possible. I must receive your request no later than 10 days before your hearing. In your request, please tell me:

- What documents you need and/or who the witnesses are;
- The location of the documents or witnesses;
- The important facts you expect the document or witness to prove; and
- Why you cannot prove these facts without a subpoena.

What Happens At the Hearing?

- I will ask you and any other witnesses to take an oath or to affirm that the testimony is true.
- You will have a chance to testify and tell me about your case.
- You and your representative (if you have one) may submit documents, present and question witnesses, state your case, and give written statements about the facts and law. You must provide your written statements no later than 5 business days before the date of your hearing.
- I will ask you and any other witnesses questions that will help me make a decision in your case.
- We will make an audio recording of the hearing.

Jennifer Lyn Brown (132-58-2507)

Page 5 of 5

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision given all the evidence of record, including the testimony at your hearing.

If You Have Any Questions

If you have any questions, please call, (888)655-6477, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

David Romeo
Administrative Law Judge

Enclosures:

Form HA-L32 (Electronic Disability Claims Processing Insert)

Form HA-504-OP1 (09-2003) ef (03-2015)

Form HA-L84 (Vocational Expert Letter)

Barcode Sheet

cc: Jonathan P Foster, Jr Jr
The Foster Law Office
303 S. Keystone Ave
Sayre, PA 18840



SOCIAL SECURITY ADMINISTRATION

Refer To:
Jennifer Lyn Brown

Office of Hearings Operations
5th Floor
300 S State St
Syracuse, NY 13202-9916
Tel: (888)655-6477 / Fax: (833)779-0462

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Jennifer Lyn Brown (132-58-2507)

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Jennifer Lyn Brown (132-58-2507)

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Jennifer Lyn Brown (132-58-2507)

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Sincerely,

David Romeo
Administrative Law Judge

Enclosures:

Form HA-504-OP1 (09-2003) ef (03-2015)

Form HA-L84 (Vocational Expert Letter)

cc: Jonathan P Foster, Jr Jr
The Foster Law Office
303 S. Keystone Ave
Sayre, PA 18840

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

Your client's case is available to be viewed electronically using the Appointed Representative Services (ARS). If you do not already have access to ARS, please contact your local hearing office to initiate the registration process. Once you have access, your client's case will be viewable at <http://ssa.gov/ar/>.

NOTE: If you are requesting direct payment of the authorized fee, you must access your clients' files electronically using ARS. We will continue to provide you a CD copy of the file on the day of the hearing at this time.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the notice. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- **Send the evidence using the Electronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.**
- **Fax the evidence using this fax number -- (877)304-5049. Remember that the enclosed barcode must be the first page for each document being faxed.**
- **Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**


**Syracuse, NY OHO
P. O. Box 9045
London, KY 40742-9045**

You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Barcodes may be used more than once when faxing evidence into the electronic file.

Form Approved
OMB NO. 0960-0671**ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING)**

(COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: Jennifer Lyn Brown	Social Security Number: 132-58-2507
Wage Earner:	Administrative Law Judge: David Romeo
Hearing Scheduled: Wednesday, July 22, 2020 at 11:30 AM Eastern (ET)	Hearing Office: Syracuse
Location of Hearing: 3345 Chambers Road Horseheads, NY 14845-1401	 RQID:000000000000000000000000278425514 SITE:X02 DR:S SSN:132582507 DOCTYPE:3005 RF:D CS:4fa3

(Check only one)

☐ **I will be available by phone at the time shown on the Notice of Hearing.** If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

☐ **I cannot be present at the time shown on the Notice of Hearing.** I request that you reschedule my hearing because:

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature:	Date:	Area Code and Telephone Number:
------------	-------	---------------------------------

☐ I have recently moved. My new address is:

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

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Claimant: Jennifer Lyn Brown	Social Security Number: 132-58-2507
Wage Earner:	Administrative Law Judge: David Romeo
Hearing Scheduled: Wednesday, July 22, 2020 at 11:30 AM Eastern (ET)	Hearing Office: Syracuse
Location of Hearing: 3345 Chambers Road Horseheads, NY 14845-1401	

(Check only one)

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3. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
4. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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SOCIAL SECURITY ADMINISTRATION

EXHIBIT NO. B10B
PAGE: 16 OF 19

Refer To:

Jennifer Lyn Brown

Office of Hearings Operations
5th Floor
300 S State St
Syracuse, NY 13202-9916
Tel: (888)655-6477 / Fax: (833)779-0462

June 24, 2020

Crc Services
P.O. Box 61148
Longmeadow, MA 01116-1148

Dear Crc Services:

The claimant named below has an application pending for disability benefits. A hearing for the claimant is scheduled, date and time shown below.

Name of Claimant: Jennifer Lyn Brown **Birth date:** 10/26/1976 **SSN:** 132-58-2507

Date and Time: Wednesday, July 22, 2020 at 11:30 AM Eastern (ET)

A member of your firm is requested to appear and give testimony as a vocational expert in the above hearing. We will call you by phone for the hearing.

Address: 300 S State St
5th Floor
Room: A
Syracuse, NY 13202-2056

A member of your firm's testimony will primarily cover the following period:

June 19, 2019 through the present.

A member of your firm's presence throughout the hearing is desired since your testimony will be based, in part, on the testimony given by the claimant and any other witnesses, including a medical advisor if needed. Copies of the pertinent exhibits tentatively selected for inclusion in the record of this case are available to you either:

- on a compact disc (CD) that will be mailed under separate cover if not enclosed with this notice,
or
- electronically at <https://secure.ssa.gov/ERECA/MEVE01View>.

To access the exhibits electronically, you must have registered for an Extra Security online account with **my Social Security**. If you have not already done so, you may register for an Extra Security online account at www.ssa.gov/myaccount/.

Please have this material available for the hearing. For additional information concerning your testimony, please see the attachment to this form letter.

Your firm's charges for this service should be submitted in accordance with your contract with the Social Security Administration.

Sincerely,

David Romeo
Administrative Law Judge

Enclosures

IMPORTANT INFORMATION

NOTE: IT IS REQUIRED THAT YOU DISQUALIFY YOURSELF IF YOU HAVE HAD ANY PRIOR KNOWLEDGE OF THIS CLAIMANT OR EXPERIENCE IN THIS CASE OTHER THAN AS A VOCATIONAL EXPERT FOR THE OFFICE OF HEARINGS OPERATIONS.

While medical factors alone may justify a finding that the claimant is or is not disabled, it is necessary in some cases to consider vocational factors in order to determine whether or not the claimant is able to engage in any substantial gainful activity. Two basic questions will be presented to you at this hearing.

The first question pertains to the kind of work, if any, the claimant can do in light of prior work activity and residual functional capacity considering age, education, training and work experience. Your testimony will be predicated on various assumptions, posed at the hearing, with respect to the claimant's residual functional capacity. You will not be expected to testify as to whether or not the claimant is under a disability, since you do not have the responsibility for deciding this ultimate legal issue. You should not express any opinion regarding the impairments involved and their effects on residual functional capacity, since these are medical matters. You will be requested to furnish a rationale and complete explanation for your opinions. In forming your judgment as to whether or not the claimant could transfer vocational skills to any other type of work, please consider only work which the claimant could perform after a normal period of training, usually given to new employees, rather than after extended vocational rehabilitation.

The second question is whether such work exists in the "national economy;" i.e., whether it exists in significant numbers either in the region where the claimant lives or in several other regions of the country. You should be prepared to testify from information gained from vocational surveys of businesses and industries (whether such surveys were made by you or by other vocational experts) and from other current vocational resource materials. You should have available, at the hearing, any such vocational resource materials that you are likely to rely upon.

Questions may also be asked of you by the claimant (or representative, if any).

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*



Form HA-510 (01-2020) UF
Discontinue Prior Editions
Social Security Administration

Page 1 of 2
OMB No.0960-0671

Waiver of Timely Written Notice of Hearing

In the case of;
Jennifer Lyn Brown
(Claimant)

Claim for:
Period of Disability and Disability Insurance Benefits

(Wage Earner)(Leave blank if same as above)

132-58-2507
(Social Security Number)

Under 20 CFR 404.938 and/or 20 CFR 416.1438, where applicable, I am entitled to receive a 75 day advance written notice of the hearing in my case. Having been fully advised of such right, I hereby waive the 75 day advance notice requirement.

Jennifer Lyn Brown
(Signature)

14 Main St. Lot 429
(Street Address)

Wellburg NY 14894
(City, State and Zip Code)

(607) 215-0584
(Area Code and Telephone Number)

Date: 6-30-2020

Office of the
Adjudicator

Office of Disability
Adjudication &

JUL 02 2020

SYRACUSE
NEW YORK

JUL 02 2020
SYRACUSE
NEW YORK



Form HA-510 (07-2017) UF

Page 2 of 2

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(b)(1), 205(d), and 1631(c) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from completing the hearing process.

We will use the information to document your waiver of rights to receive the written Notice of Hearing. We may also share your information for the following purposes, called routine uses:

1. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and
2. To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for the SSA as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*



K Appeals Council Request for Review Tracking System



Case Details



You have successfully completed the intake process. Please establish the request for review record in ARPS.

The case will remain available in this system for **30 days**. You may make changes during this time.

Preparer Information

Preparer's Name

Peter Gorton

Preparer's Address

1500 East Main Street
P O Box 89
Not Answered
Endicott, New York,
13760

Daytime Phone Number

(607) 754-0500 ext. *Not Answered*

Claimant Information

Claimant's Name

Jennifer Lynn Brown

Claimant's Address

14 Main Street
Lot 429
Not Answered
Wellsburg, New York,
14894

Daytime Phone Number

(607) 215-0584 ext. *Not Answered*

Email Address

Not Answered

Does claimant live at the above address?

Yes

Alternative Phone Number

Not Answered

SSN

132-58-2507

Claim Number

132582507

Request Information

Level of Appeal

HA-520

SSA Program Title

Retirement, Survivors and
Disability Insurance

Notice Date

08/07/2020

Reason for Appeal

I am totally disabled from performing any substantial gainful activity

Extension of Time

Yes

Attached Files

Attached Files

No

Case Status

Completed

Date Submitted

09/22/2020

Submitted By

Representative

Remarks

This case has already been established in ARPS. - the IAP520
has been uploaded to the CEF

Employee

TAKSAM

Edit

Print Page

Back to Search Results

ICLM SUMMARY

132-58-2507

JUNE 19, 2019

Your information was received on June 19, 2019 at 9:21:21 PM.

Identification

Applicant Identification

Name: JENNIFER LYN BROWN

Social Security Number: ***-**-2507

Date of Birth: October 26, 1976

Gender: Female

Blind or low vision: No

Disabled: Yes

Start Date of Disability: June 19, 2019

Denied Benefits in Last 60 days: No

Diagnosed with condition that is expected to end in death: No

Applicant's Contact Information

Contact Information

Mailing Address: 14 MAIN ST LOT 429, WELLSBURG, New York, 14894

Reside at this address: Yes

Phone: (607) 215-0584 Home

Best time to call: 9 a.m. to Noon

Email Address: jenlyn9598@yahoo.com

Confirm Email Address: jenlyn9598@yahoo.com

Ability to Communicate in English

Speak English: Yes

Read English: Yes

Write English: Yes

Language Preferences

Preferred language for speaking: English

Preferred language for reading: English

Birth and Citizenship Information

Place of Birth: SAYRE, Pennsylvania

U.S. Citizen: Yes

Type of Citizenship: US citizen born inside US

Other Social Security Numbers and Names

Other Social Security Numbers

Any other Social Security Numbers used: No

Other Names

Any other names used: Yes

Other Name 1: Jennifer Lyn Evans

General

Marriage Information

Currently married: Yes

Spouse's Name: Eric Brown

Spouse's Social Security Number: 160-62-3940

Know Spouse's date of birth: Yes

Spouse's date of birth: December 19, 1975

Date of Marriage: May 6, 2000

Place of Marriage: Athens, Pennsylvania

Marriage Type: Married by Clergy or Public Official

Prior Marriages
Any prior marriages: No

Children
Have any children: No

Military Details
Military service prior to 1968: No

Employer Details
Worked for an employer in 2018: Yes
Worked or will work for an employer in 2019: Yes

Employer Details 1
Employer's name: GUTHRIE CLINIC
Employer's address: 1 GUTHRIE SQUARE, SAYRE, Pennsylvania, 18840
Date employment began: January 2000
Date employment ended: June 2019
Employment has not ended: No

Self-Employment Details
Self-employed in 2018: No
Self-employed in 2019: No

Supplemental Information
Worked outside the US: No
Spouse worked outside the US: No
Agree with earnings history as shown on Social Security statement: Yes

Total Earnings
Total of all wages and tips in 2018: \$36270
Worked outside the United States for salary, wages, or self-employment in 2018:
No
Total of all wages and tips in 2019: \$20114
Worked outside the United States for salary, wages, or self-employment in 2019:
No
Total earnings include any special payments paid in one year but earned in
another: No

Other Pensions/Annuities
Ever work in a job where U.S. Social Security taxes were not deducted or
withheld: No
Spouse worked for the Railroad 5 years or more: No

Direct Deposit Details
Own or co-own a bank account to use for Direct Deposit: Yes
Account Type: Checking
Routing Number: 231388494
Account Number: 1690063480

Other Benefits

Benefit Information
Intend to apply for Supplemental Security Income benefits: No
Any previous application(s) for Medicare, Social Security, or Supplemental
Security Income benefits: Yes
Types of benefits for which application submitted: Social Security benefits
Application for benefits submitted on own Social Security Number: Yes

Ability To Work

Illnesses, injuries, conditions related to work: No
Now able to work: No

Disability Payments

Filed or intend to file for workers' compensation or other public disability benefits: No

Received money from employer on/after date unable to work: Yes

Total amount received from employer: \$482.31

Type(s) of pay received: Vacation Pay

Expect to receive money from employer in the future: No

Dependents

Has one parent who receives one-half support: No

Remarks

Remarks

The following are your remarks: I estimated my last amount of pay (vacation pay) from my employer as I have not received it yet. I am currently out on medical leave. Last date of medical leave is July 5, 2019. I submitted my resignation today June 19, 2019, I have Crohn's disease, Rheumatoid Arthritis, Anxiety, and Depression. I am repeatedly having flares of the Crohn's Disease and Rheumatoid Arthritis and it is causing fatigue, stress, swelling in my joints, bathroom issues, etc and I cannot work under these conditions. I am also married, but separated and have been since 2015. In the process of the divorce.

Authorization to Obtain Wage Info for JENNIFER BROWN

Authorization to Obtain Wage Information

Your information was received on June 19, 2019 at 9:21:21 PM.

Authorization for the SSDI program: Yes

PAGE 1

SG-SSA-16

175

June 27, 2019, 08:48

PAGE 2

NH 132-58-2507

SG-SSA-16

I HAD NO PREVIOUS MARRIAGES THAT LASTED 10 YEARS OR MORE OR ENDED IN DEATH.

I DO NOT HAVE ANY CHILDREN UNDER AGE 18; AGE 18-19 ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL TIME; OR AGE 18 OR OVER AND DISABLED BEFORE AGE 22 WHO MAY BE ELIGIBLE FOR SOCIAL SECURITY BENEFITS ON THIS RECORD. THIS INCLUDES CHILDREN WHO MAY OR MAY NOT BE LIVING WITH ME.

REMARKS:

I AGREE WITH THE EARNINGS AS SHOWN ON MY SOCIAL SECURITY STATEMENT.

WORK:FOREIGN-2018=N 2019=N

USTAXESPD-2018=? 2019=?

I KNOW THAT ANYONE WHO MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF MATERIAL FACT IN AN APPLICATION OR FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW BY FINE, IMPRISONMENT OR BOTH. I AFFIRM THAT ALL INFORMATION I HAVE GIVEN IN CONNECTION WITH THIS CLAIM IS TRUE.

MY TELEPHONE NUMBER IS (607) 215-0584.

Cigna Group Insurance
PO Box 29221
Phoenix, AZ 85038-9221

PAGE 1 OF 2

EXHIBIT NO. B3D
PAGE: 1 of 8

Cigna.

JULIA A

800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide
your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
Claimant: JENNIFER L BROWN
Account Name: THE GUTHRIE CLINIC
Policy/Plan: SHD 0963219
Div: 000

P031

JENNIFER L BROWN
14 MAIN STREET LOT 429
WELLSBURG NY 14894

Disability Income	05/30/2019 - 06/02/2019	2 Days	838.80/7DAYWK	335.52	48.94
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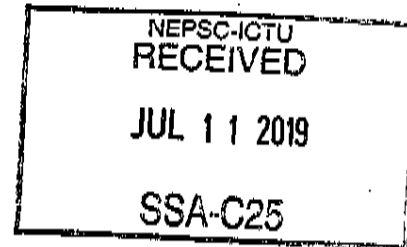
Deductions

Federal Income Tax 28.00
FICA 20.94

TOTAL PAYMENTS \$ 286.58

Payments Issued 05/30/2019

JENNIFER L BROWN 286.58



GCNM

Total amount paid to date, including taxes, for this claim is \$ 335.52 for the period 05/30/2019 thru 06/02/2019

Detach on Perforation Below - Please Cash Promptly

Cigna Group Insurance
PO Box 29221
Phoenix, AZ 85038-9221

Explanation Of Benefits

EXHIBIT NO. B3D

PAGE: 2 OF 8



JULIA A
800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
Claimant: JENNIFER L BROWN
Account Name: THE GUTHRIE CLINIC
Policy/Plan: SHD 0963219
Div: 000

P031

JENNIFER L BROWN
14 MAIN STREET LOT 429
WELLSBURG NY 14894

Disability Income	06/03/2019 - 06/09/2019	5 Days	838.80/7DAYWK	838.80	122.36
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Deductions

Federal Income Tax 70.00
FICA 52.36

TOTAL PAYMENTS \$ 716.44

Payments Issued 06/04/2019
JENNIFER L BROWN 716.44

102270220201

GCNM

Total amount paid to date, including taxes, for this claim is \$ 1,174.32 for the period 05/30/2019 thru 06/09/2019

Detach on Perforation Below - Please Cash Promptly

Cigna Group Insurance
PO Box 29221
Phoenix, AZ 85038-9221

PAGE 1 OF 2

EXHIBIT NO. B3D
PAGE: 3 OF 6
Cigna.

JULIA A
800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
Claimant: JENNIFER L BROWN
Account Name: THE GUTHRIE CLINIC
Policy/Plan: SHD 0963219
Div: 000

P031

JENNIFER L BROWN
14 MAIN STREET LOT 429
WELLSBURG NY 14894

Disability Income	06/10/2019 - 06/16/2019	- 5 Days	038.80/DAYWK	838.80	122.36
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Deductions

Federal Income Tax 70.00
FICA 52.36

TOTAL PAYMENTS \$ 716.44

Payments Issued 06/11/2019

JENNIFER L BROWN 716.44



Total amount paid to date, including taxes, for this claim is \$ 2,013.12 for the period 05/30/2019 thru 06/16/2019

Detach on Perforation Below - Please Cash Promptly

Cigna Group Insurance
PO Box 29221
Phoenix, AZ 85038-9221

Explanation of Benefits

EXHIBIT B3D
PAGE: 4 of 8
Cigna.

PAGE 1 OF 2

JULIA A

800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide
your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
Claimant: JENNIFER L BROWN
Account Name: THE GUTHRIE CLINIC
Policy/Plan: SHD 0963219
Div: 000

P031

JENNIFER L BROWN
14 MAIN STREET LOT 429
WELLSBURG NY 14894

Disability Income	06/17/2019 - 06/23/2019	5 Days	838.80/7DAYWK	838.80	122.36
TOTAL PAYMENTS \$					716.44
Deductions					
Federal Income Tax	70.00				
FICA	52.36				
Payments Issued 06/18/2019					
JENNIFER L BROWN					716.44

Total amount paid to date, including taxes, for this claim is \$ 2,851.92 for the period 05/30/2019 thru 06/23/2019

Attention Below - Please Cash Promptly



ECNM

PO Box 29221
 Phoenix, AZ 85038-9221

PAGE 1 OF 2

EXHIBIT NO. B3D
 PAGE: 5 of 8
 Cigna.

JULIA A
800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
 Claimant: JENNIFER L BROWN
 Account Name: THE GUTHRIE CLINIC
 Policy/Plan: SHD 0963219
 Div: 000

P031

JENNIFER L BROWN
 14 MAIN STREET LOT 429
 WELLSBURG NY 14894

Disability Income	06/24/2019 - 06/30/2019	5 Days	754.92/7DAYWK	--	-- 754.92	--	108.72
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Deductions

FICA 47.12
Federal Income Tax 61.60

TOTAL PAYMENTS \$ 646.20

Payments Issued 06/25/2019

JENNIFER L BROWN 646.20



Total amount paid to date, including taxes, for this claim is \$ **3,606.84** for the period **05/30/2019** thru **06/30/2019**

Detach on Perforation Below - Please Cash Promptly

Cigna Group Insurance
PO Box 29221
Phoenix, AZ 85038-9221

PAGE 1 OF 2

EXHIBIT NO. B3D
PAGE: 6 of 8
Cigna.

JULIA A
800-238-2125 Ext.

Please direct any questions to the above analyst. Be sure to provide your account and ID numbers in all letter and telephone calls.

Certholder: JENNIFER L BROWN
Claimant: JENNIFER L BROWN
Account Name: THE GUTHRIE CLINIC
Policy/Plan: SHD 0963219
Div: 000

P031

JENNIFER L BROWN
14 MAIN STREET LOT 429
WELLSBURG NY 14894

Disability Income	07/01/2019 - 07/05/2019	5 Days	629.10/7DAYWK	629.10	88.27
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Deductions

FICA 39.27
Federal Income Tax 49.00

TOTAL PAYMENTS \$ 540.83

Payments Issued 07/02/2019

JENNIFER L BROWN 540.83



GCNM

Total amount paid to date, including taxes, for this claim is \$ 4,235.94 for the period 05/30/2019 thru 07/05/2019

Guthrie Medical Group, P.C.
1 Guthrie Square
Sayre, PA 18840
570/887-4263

Pay Group: 90N-Clinic Non-Exempt
Pay Begin Date: 06/16/2019
Pay End Date: 06/29/2019

Business Unit: 90000
Advice #: 569562
Advice Date: 07/05/2019

		TAX DATA:		Federal	PA State
Jennifer Eyn Brown 14 Main Street Lot #429 Wellsburg, NY 14894	Employee ID:	GC340616	Tax Status:	Single	N/A
	Department:	41290000-Gastroenterology	Allowances:	2	0
	Location:	Sayre PA	Addl. Percent:		
	Job Title:	Supervisor, Office Operations	Addl. Amount:	10.00	
	Pay Rate:	\$20.92/Hourly			

HOURS AND EARNINGS						TAXES		
Description	Rate	Current Hours	Earnings	Hours	Earnings	Description	Current	YTD
Paid Time Off - Final Payout	20.97	23.79	498.88	23.79	498.88	Fed Withholding	12.97	1,518.64
Award			0.00		150.00	Fed MED/EE	7.24	271.35
Overtime @ 1/2 FLSA Rate			0.00	6.50	68.10	Fed OASDI/EE	30.83	1,160.24
Paid Time Off			0.00	106.00	2,220.66	NY Withholding	0.00	30.71
Regular Earnings			0.00	844.00	17,675.44	PA Unempl EE	0.30	12.37
						PA Withholding	15.32	574.49
						PA SAYRE BORO Withholding	4.99	187.14
						PA SAYRE LS Tax	2.00	26.00
TOTAL:		0.00	498.88	950.00	20,613.08	TOTAL:	73.75	3,780.94

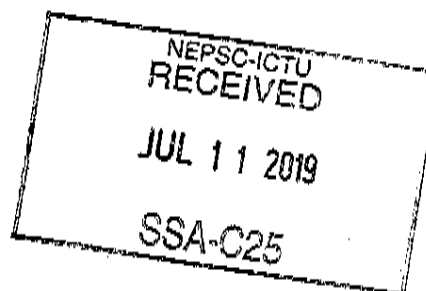
BEFORE-TAX DEDUCTIONS			AFTER-TAX DEDUCTIONS			EMPLOYER PAID BENEFITS		
Description	Current	YTD	Description	Current	YTD	Description	Current	YTD
Health Care	0.00	461.32	Clinic Pharmacy	91.59	1,134.50	Long Term Disability-Enhanced	0.00	74.28
403(B) Retirement Savings Plan	0.00	402.28	Employee Giving	2.00	26.00	Basic Life Ins. PT	0.00	42.25
Dental	0.00	148.08	Long Term Disability-Enhanced	0.00	139.39	Guthrie Network Advantage	0.00	5,491.46
Guthrie Network Advantage	0.00	1,289.88	Short Term Disability-Enhanced	0.00	150.78			
TOTAL:	0.00	2,301.76	TOTAL:	93.59	1,450.67	*TAXABLE		

TOTAL GROSS	FED TAXABLE GROSS	TOTAL TAXES	TOTAL DEDUCTIONS	NET PAY
Current 498.88	498.88	73.75	93.59	331.54
YTD 20,613.08	18,311.32	3,780.94	3,752.43	13,079.71

Time	Balance	Max
PTO	0.0	272.0

NET PAY DISTRIBUTION			
Advice #	Account Type	Account Number	Deposit Amount
569562	Savings	XXXXXX3480	75.00
	Checking	XXXXXX3480	256.54
TOTAL:			331.54

MESSAGE:





INSERT THIS END FIRST



Client Name: Jennifer Lyn Brown

Document Description: SEI/Wage Verification

Form Name: SEI/WGVER

Printed by: N. Li



RQID:BD560437156 SITE:C25 DR:S
SSN:132582507 DOCTYPE:0521 RF: CS:1d14

Request ID:	BD560437156
Site ID:	C25
SSN:	132-58-2507
Document Type:	0521

Form Specific Information:

DETAIL COVERED FICA EARNINGS AND EMPLOYER NAME AND ADDRESS FOR YEARS
REQUESTED

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
% MICHELE SISTO
1 GUTHRIE SQ
SAYRE PA 18840-1625

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0005	AA		J L BROWN	16223.10	16223.10	5093-87-57989	01206	V
			WAGE TOTAL	16223.10				
			OASDI EMPLOYER TOTAL	16223.10				
			05 OASDI YEARLY TOTAL	16223.10				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0006	AA		J L BROWN	18527.15	17884.37	6058-88-37889	00707	V
			WAGE TOTAL	18527.15				
			OASDI EMPLOYER TOTAL	18527.15				
			06 OASDI YEARLY TOTAL	18527.15				

EIN: 043376070 UNUM LIFE INSURANCE COMPANY OF
AMERICA THIRD PARTY PLANS
% AMANDA C RAINS OPTAX 6S625
1 FOUNTAIN SQ
CHATTANOOGA TN 37402-1307

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0007	AA		J L BROWN	360.60	360.60	8101-BT-96718	01208	V
			WAGE TOTAL	360.60				
			OASDI EMPLOYER TOTAL	360.60				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0007	AA		J L BROWN	19987.65	18716.58	8086-AS-21754	01008	V
			WAGE TOTAL	19987.65				
			OASDI EMPLOYER TOTAL	19987.65				
			07 OASDI YEARLY TOTAL	20348.25				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0008	AA		J L BROWN	21811.13	20425.32	9049-AT-68263	00409	V
			WAGE TOTAL	21811.13				
			OASDI EMPLOYER TOTAL	21811.13				
			08 OASDI YEARLY TOTAL	21811.13				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0009	AA		J L BROWN	21995.10	20521.44	0040-AP-23706	00410	V
			WAGE TOTAL	21995.10				
			OASDI EMPLOYER TOTAL	21995.10				
			09 OASDI YEARLY TOTAL	21995.10				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0010	AA		J L BROWN	21017.76	19560.49	1049-AV-28303	00611	V
			WAGE TOTAL	21017.76				
			OASDI EMPLOYER TOTAL	21017.76				
			10 OASDI YEARLY TOTAL	21017.76				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR REO LOAC NAME EARNINGS
0011 AA J L BROWN 21885.81
WAGE TOTAL 21885.81
OASDI EMPLOYER TOTAL 21885.81
11 OASDI YEARLY TOTAL 21885.81

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0012 AA J L BROWN 24455.93 22758.38 3044-AJ-33174 00513 V
WAGE TOTAL 24455.93
OASDI EMPLOYER TOTAL 24455.93
12 OASDI YEARLY TOTAL 24455.93

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0013 AA J L BROWN 22729.68 21131.05 4057-AZ-17956 00314 V
WAGE TOTAL 22729.68
OASDI EMPLOYER TOTAL 22729.68

EIN: 420127290 PRINCIPAL LIFE INSURANCE COMPANY
% HR PAY AND BENEFITS S-3-S60
711 HIGH ST
DES MOINES IA 50392-0001
0013 AA J BROWN 1054.20 1054.20 4115-AC-02383 01214 V
WAGE TOTAL 1054.20
OASDI EMPLOYER TOTAL 1054.20
13 OASDI YEARLY TOTAL 23783.88

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0014 AA J L BROWN 14168.75 13146.64 5068-AN-23302 00915 V
WAGE TOTAL 14168.75
OASDI EMPLOYER TOTAL 14168.75

EIN: 420127290 PRINCIPAL LIFE INSURANCE COMPANY
0014 AA J BROWN 3472.20 3472.20 5114-AA-55530 01615 V
WAGE TOTAL 3472.20
OASDI EMPLOYER TOTAL 3472.20
14 OASDI YEARLY TOTAL 17640.95

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0015 AA J L BROWN 14904.91 14439.52 6055-BA-19568 00716 V
WAGE TOTAL 14904.91
OASDI EMPLOYER TOTAL 14904.91
15 OASDI YEARLY TOTAL 14904.91

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0016 AA J L BROWN 26461.41 26129.47 7034-EV-95713 00917 V
WAGE TOTAL 26461.41
OASDI EMPLOYER TOTAL 26461.41
16 OASDI YEARLY TOTAL 26461.41

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S
0017 AA J L BROWN 32804.68 32407.87 8030-LN-57431 00818 V
WAGE TOTAL 32804.68
OASDI EMPLOYER TOTAL 32804.68
17 OASDI YEARLY TOTAL 32804.68

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
RPYR REO LOAC NAME EARNINGS TOTAL COMP CONTROL NUMBER PR S

EIN: 061252418 LINA BENEFIT PAYMENTS INC
TAX DEPT LL TCU
900 COTTAGE GROVE RD
HARTFORD CT 06152-0001

RPYR	REO	LOAC	NAME	EARNINGS	TOTAL COMP	CONTROL NUMBER	PR	S
0019	AA		J L BROWN	3473.48	3473.48	0021-AD-88095	00720	V
			WAGE TOTAL	3473.48				
			OASDI EMPLOYER TOTAL	3473.48				

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

0019	AA		J L BROWN	18713.60	18311.32	0028-HQ-22687	00820	V
			WAGE TOTAL	18713.60				
			OASDI EMPLOYER TOTAL	18713.60				
			19 OASDI YEARLY TOTAL	22187.08				

20 NONE

DETAIL NON-COVERED EARNINGS AND W-2 PENSION DATA AND EMPLOYER NAME AND ADDRESS FOR YEARS REQUESTED
05 NONE

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0006	DD		J L BROWN	642.78	6058-88-37889	00707	V
			DEFERRED COMP 401 (K) TOTAL	642.78			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0007	DD		J L BROWN	1271.07	8086-AS-21754	01008	V
			DEFERRED COMP 401 (K) TOTAL	1271.07			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0008	DD		J L BROWN	1385.81	9049-AT-68263	00409	V
			DEFERRED COMP 401 (K) TOTAL	1385.81			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0009	DD		J L BROWN	1473.66	0040-AP-23706	00410	V
			DEFERRED COMP 401 (K) TOTAL	1473.66			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0010	DD		J L BROWN	1457.27	1049-AV-28303	00611	V
			DEFERRED COMP 401 (K) TOTAL	1457.27			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0011	DD		J L BROWN	1525.66	2048-AE-52818	00612	V
			DEFERRED COMP 401 (K) TOTAL	1525.66			

EIN: 250815795 GUTHRIE MEDICAL GROUP PC

RPYR	RE	LOAC	NAME	TOTAL AMOUNT	CONTROL NUMBER	PR	S
0012	DD		J L BROWN	1697.55	3044-AJ-33174	00513	V

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0013 DD J L BROWN 1598.63 4057-AZ-17956 00314 V
 DEFERRED COMP 401(K) TOTAL 1598.63

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0014 DD J L BROWN 1022.11 5068-AN-23302 00915 V
 DEFERRED COMP 401(K) TOTAL 1022.11
 EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0015 DF J L BROWN 465.39 6055-BA-19568 00716 V
 DEFERRED COMP 403(B) TOTAL 465.39

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0016 DF J L BROWN 331.94 7034-EV-95713 00917 V
 DEFERRED COMP 403(B) TOTAL 331.94

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0017 DF J L BROWN 396.81 8030-LN-57431 00818 V
 DEFERRED COMP 403(B) TOTAL 396.81

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0018 DF J L BROWN 284.15 9028-DC-73424 00819 V
 DEFERRED COMP 403(B) TOTAL 284.15

EIN: 250815795 GUTHRIE MEDICAL GROUP PC
 RPYR RE LOAC NAME TOTAL AMOUNT CONTROL NUMBER PR S
 0019 DF J L BROWN 402.28 0028-HQ-22687 00820 V
 DEFERRED COMP 403(B) TOTAL 402.28

20 NONE

REMARKS

CLAIMS ACTIVITY--SEE MBR

CLAIMS ACTIVITY--SEE SSR

SUMMARY FICA EARNINGS FOR YEARS REQUESTED

YEAR	EARNINGS	YEAR	EARNINGS	YEAR	EARNINGS	YEAR	EARNINGS
1994	414.28	2001	15788.69	2008	21811.13	2014	17640.95
1995	4208.30	2002	16274.63	2009	21995.10	2015	14904.91
1996	3412.56	2003	16472.14	2010	21017.76	2016	26461.41
1997	7035.56	2004	15712.26	2011	21885.81	2017	32804.68
1998	9334.14	2005	16223.10	2012	24455.93	2018	36554.41
1999	12063.54	2006	18527.15	2013	23783.88	2019	22187.08
2000	13390.77	2007	20348.25				

SUMMARY MQGE EARNINGS FOR YEARS REQUESTED

NO MQGE EARNINGS FOR YEARS REQUESTED

REMARKS

CLAIMS ACTIVITY--SEE MBR

NO UNEMPLOYMENT REPORT.

NEW HIRE INFORMATION Date: 05/13/2020

NO NEW HIRE REPORT.

WAGE INFORMATION Date: 05/13/2020 SSN: 132-58-2507

QUARTER PAID: 3RD/2019 NAME (F,MI,L): J L BROWN WAGES PAID: \$499 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: 1 GUTHRIE SQ CITY ST ZIP: SAYRE, PA 18840-1625 REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2020-02-11
QUARTER PAID: 2ND/2019 NAME (F,MI,L): J L BROWN WAGES PAID: \$8276 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: 1 GUTHRIE SQ CITY ST ZIP: SAYRE, PA 18840-1625 REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2019-10-07
QUARTER PAID: 1ST/2019 NAME (F,MI,L): J L BROWN WAGES PAID: \$11838 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: 1 GUTHRIE SQ CITY ST ZIP: SAYRE, PA 18840-1625 REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2019-07-08
QUARTER PAID: 4TH/2018 NAME (F,MI,L): J L BROWN WAGES PAID: \$9370 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: ATTN: CHRISTINA MACRONALD GUTHRIE SQUARE CITY ST ZIP: SAYRE, PA 18840- REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2019-04-08
QUARTER PAID: 3RD/2018 NAME (F,MI,L): J L BROWN WAGES PAID: \$12224 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: ATTN: CHRISTINA MACRONALD GUTHRIE SQUARE CITY ST ZIP: SAYRE, PA 18840- REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2019-01-07
QUARTER PAID: 3RD/2018 NAME (F,MI,L): JENNIFER L BROWN WAGES PAID: \$11123 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: 1 GUTHRIE SQ CITY ST ZIP: SAYRE, PA 18840-1625 REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2019-01-02
QUARTER PAID: 2ND/2018 NAME (F,MI,L): J L BROWN WAGES PAID: \$8961 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: ATTN: CHRISTINA MACRONALD GUTHRIE SQUARE CITY ST ZIP: SAYRE, PA 18840- REPORTED BY: PA	NAME/SSN VERIFIED: Y BN: 250815795 REPORT PROCESSED: 2018-10-09
QUARTER PAID: 2ND/2018 NAME (F,MI,L): JENNIFER L BROWN WAGES PAID: \$8048 EMPLOYER: GUTHRIE MEDICAL GROUP PC EMPLOYER ADDRESS: 1 GUTHRIE SQ	NAME/SSN VERIFIED: Y BN: 250815795

NH NAME JENNIFER L BROWN SN:132-58-2507 PG 001+
 INPUT 05/13/20 DO:X02 UNIT:EZTOOL DERO MOD:03
 RUN DATE 05/13/20 V:05/03/19
 CONTROL 132-58-2507

EVENT ICERS EARNINGS RECORD
 TID CERTIFIED EARNINGS RECORD
 ALERTS NH HAS 14 YOC'S FOR NONCOVERED PENSION PIA
 PRIOR CLAIM DATA DOES NOT EXIST ON DRAMS
 POSSIBLE INCOMPLETES 2019
 NH HAS 14 DIS EX YOC'S FOR NONCOVERED PENSION PIA

INFORMTNL DISABILITY NON-EXCLUSION 20/40 INSURED TEST MET
 DISABILITY EXCLUSION FULLY INSURED STATUS MET
 DISABLED NH IS FULLY INSURED RIB
 DISABILITY NON-EXCLUSION FULLY INSURED STATUS MET
 DISABILITY EXCLUSION 20/40 INSURED TEST MET
 PRIOR CLAIM STATUS - A

ID INFO REQ NAME:BROWN REQ SEX:F REQ DATE OF BIRTH:10/26/1976

DATES FILING DATE:06/19/19 DATE OF ONSET:06/19/2019

DIB INPUT MBR/INPUT DATA
 ONSET:08/14/2014 DENIAL/DISALLOWANCE:J1
 ONSET:06/19/2019 DENIAL/DISALLOWANCE:J1

INS STAT DISABILITY: EXCL REQ QC:21 EXCL HAS:040
 NON-EXCL REQ QC:21 NON-EXCL HAS:040 DIS DLI:12/24
 OTHER: FIRST INSURED:04/14

TOT COV SSA QC
 1937 THRU 1950 QC: 0
 WAGE QC AFTER 1946: 100 WAGE QC AFTER 1950: 100
 SE QC:NONE AG QC:NONE

TOT EARN SSA
 TOT AFTER 1936: 454708.42
 TOT AFTER 1950: 454708.42

COMPUTATIONAL YEARLY EARNINGS

MAX	AMT	YR	QC	REGULAR	U	NH INDEXED	RAILROAD	RQSM	DMW	SE	AG
60600	620	94	NNNN	414.28		877.65					
61200	630	95	CCCC	4208.30		8571.70					
62700	640	96	CCCC	3412.56		6626.81					
65400	670	97	CCCC	7035.56		12909.02					
68400	700	98	CCCC	9334.14		16274.71					
72600	740	99	CCCC	12063.54		19923.31					
76200	780	00	CCCC	13390.77	L	20956.39					

80400	830	01	CCCC	15788.69	H	24133.37
84900	870	02	CCCC	16274.63	H	24629.13
87000	890	03	CCCC	16472.14	H	24333.20
87900	900	04	CCCC	15712.26	H	22179.60
90000	920	05	CCCC	16223.10	L	22092.34
94200	970	06	CCCC	18527.15	H	24121.27
97500	1000	07	CCCC	20348.25	H	25342.17

NH NAME JENNIFER L BROWN
INPUT 05/13/20

SN:132-58-2507 PG 002

DO:X02 UNIT:EZTOOL DERO MOD:03

COMPUTATIONAL YEARLY EARNINGS

MAX	AMT	YR	QC	REGULAR	U	NH INDEXED	RAILROAD	RQSM	DMW	SE	AG
102000	1050	08	CCCC	21811.13	H	26553.24					
106800	1090	09	CCCC	21995.10	H	27187.21					
	1120	10	CCCC	21017.76	H	25379.32					
	1120	11	CCCC	21885.81	H	25624.60					
110100	1130	12	CCCC	24455.93	H	27766.75					
113700	1160	13	CCCC	23783.88	H	26662.93					
117000	1200	14	CCCC	17640.95		19098.47					
118500	1220	15	CCCC	14904.91		15593.86					
	1260	16	CCCC	26461.41	H	27375.19					
127200	1300	17	CCCC	32804.68	H	32804.68					
128400	1320	18	CCCC	36554.41	H	36554.41					
132900	1360	19	CCCC	22187.08		22187.08					
137700	1410	20	NNNN								

COMP DATA DI - COMP TYPE:NS 78 DIS EX AIME: \$2174.00

EFF DATE:12/19 PIA:\$1252.40 PIFC:L FAM MAX: \$1877.40

START BASE YEAR/START DATE:1951 LAST BASE YEAR/CLOSE DATE:2018

DIVIDEND: \$443695.80 DM:204 DOY:4 YOC: I/Y: ELG YR:2019

DI - COMP TYPE:NS 78R DIS EX AIME: \$2181.00

EFF DATE:01/20 PIA:\$1254.70 PIFC:L FAM MAX: \$1882.10

START BASE YEAR/START DATE:1951 LAST BASE YEAR/CLOSE DATE:2019

DIVIDEND: \$444926.49 DM:204 DOY:4 YOC: I/Y: ELG YR:2019

TRIAL COMPUTATIONS: NS 78 \$1252.40 SP MIN \$486.60 NS 78R

\$1254.70 SP MINR \$530.70

(3368) Section 1 - Information About the Disabled Person**1.A. Name (First, Middle Initial, Last) Jennifer Lyn Brown****1.B. Social Security Number 132-58-2507**

1.C. Mailing Address (Street or PO Box) 14 MAIN ST LOT 429
 Include apartment number if applicable, **WELLSBURG, NY 14894**
 City, State/Province, Zip/Postal Code,
 Country (if not USA)

1.D. Email Address jenlyn9598@yahoo.com**1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.**Phone number **607-215-0584**

Check this box if you do not have a phone or number where we can leave a message

1.F. Alternate Phone Number - another number where we may reach you, if any

Alternate phone number

1.G. Can you speak and understand English? Yes

If no, what language do you prefer?

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? Yes**1.I. Can you write more than your name in English? Yes****1.J. Have you used any other names on your medical or educational records? Yes**

Examples are maiden name, other married name or nickname.

If yes, please list them here: **Jennifer Lyn Evans****(3368) Section 2 - Contacts**

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)	Jonathan George Foote
2.B. Relationship to you:	Friend
2.C. Daytime Phone Number (as described in 1.E. above)	607-215-0584
2.D. Mailing Address (Street or PO Box)	14 MAIN ST LOT 429
Include apartment number or unit if applicable,	WELLSBURG, NY 14894
City, State/Province, Zip/Postal Code,	
Country (if not USA)	

2.F. Who is completing this report? **The disabled person listed in 1.A. (Go to SECTION 3 - MEDICAL CONDITIONS).**

(3368) Section 3 - Medical Conditions

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. Rheumatoid Arthritis
2. Crohn's Disease
3. Depression
4. Anxiety

3.B. What is your height without shoes? **5' 11"**

3.C. What is your weight without shoes? **286 lbs.**

3.D. Do your conditions cause you pain or other symptoms? **Yes**

(3368) Section 4 - Work Activity

4.A. Are you currently working?

No, I have stopped working (Go to question 4.C. below)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year)

05/23/2019

Why did you stop working?

Because of my condition(s).

Because of other reasons.

Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed)

Shoulder Surgery

Even though you stopped working for other reasons, when do you believe your conditions(s) became severe enough to keep you from working? (month/day/year)

06/19/2019

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours or rate of pay)

No (Go to Section 5 - Education and Training)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than \$1220 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

(3368) Section 5 - Education and Training Information

5.A. Check the highest grade of school completed. **2 years of college**

Date Completed: **05/1998**

5.B. Did you attend special education classes? **No** (Go to 5.C.)

5.C. Have you completed any type of specialized job training, trade or vocational school?

No

(3368) Section 6 - Job History

6.A. List the jobs (up to 5) that you had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate Of Pay	
		From mm/yy	To mm/yy			Amount	Frequency
Supervisor Office Operations	Hospital	JANUARY 2000	JUNE 2019	8	5	\$20.97	Hour

Check the box below that applies to you.

I had only one job in the last 15 years before I became unable to work. Answer the questions below.

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

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 EXHIBIT NO. B1E
 PAGE 4 OF 11

6.B. Describe this job. What did you do all day?
 I sat for long periods of time, typing, data entry, answering phones, supervising 17 employees- time cards, vacation slips/their time off/assisted manager, managed Dr schedules, set up meetings, went to meetings, worked on LEAN projects, overseen the entire Gastroenterology Department.

6.C. In this job, did you:
 Use machines, tools or equipment? **Yes**
 Use technical knowledge or skills? **Yes**
 Do any writing, complete reports, or perform any duties like this? **Yes**

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk	1.5	Stoop (Bend down & forward at the waist)	0	Handle large objects	0
Stand	0.5	Kneel (Bend legs to rest on knees)	0	Write, type or handle small objects	8
Sit	8	Crouch (Bend legs & back down & forward)	0	Reach	8
Climb	0	Crawl (Move on hands & knees)	0		

6.E. Lifting and carrying (Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job): **I did not lift because I was unable to as I hurt my shoulder a year ago- Bursitis, Bone Spur, and recently had shoulder surgery.**

6.F. Check **heaviest** weight lifted: **Less than 10 lbs.**

6.G. Check weight **frequently** lifted (by frequently, we mean from 1/3 to 2/3 of the workday.): **Less than 10 lbs.**

6.H. Did you supervise other people in this job? **Yes**
 How many people did you supervise? **17**
 What part of your time did you spend supervising people? **8 hours or more**
 Did you hire and fire employees? **Yes**

6.I. Were you a lead worker? **Yes**

(3368) Section 7 - Medicines

7. Are you taking any medicines (prescription or non-prescription)?
Yes (Give the information requested below. You may need to look at your medicine containers.)

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Name of Medicine	If prescribed, give name of doctor	Reason for medicine
buPROPion 300 MG Tb24 Commonly known as: WELLBUTRIN XL	Michael Gillan DR, Guthrie Clinic	Anxiety/Depression EXHIBIT NO. B1E PAGE: 5 OF 11
calcium carbonate 600 MG Tabs	THOMAS J MCDONALD JR	Calcium Low Blood Count
ergocalciferol 50000 units Caps	Michael Georgetson DR, Guthrie Clinic	Low Blood Count
foliC acid 1 MG Oral Tab	Michael Georgetson DR, Guthrie Clinic	Low Blood Count
Humira	Preetika Sinh DR, Guthrie Clinic	Crohn's Disease
methotrexate sodium (PF) 50 MG/2ML Soln	James Freeman DR, Guthrie Clinic	Inflammation
ondansetron 8 MG Tbdp Commonly known as: ZOFRAN ODT	Preetika Sinh DR, Guthrie Clinic	Nausea
pantoprazole 40 MG Tbec	Michael Gillan DR, Guthrie Clinic	Acid Reflux
Remicade	Preetika Sinh DR, Guthrie Clinic	Crohn's Disease
Ustekinumab 90 MG/ML Subcutaneous-Stelara injection	Michael Georgetson DR, Guthrie Clinic	Chron's Disease
venlafaxine 150 MG Cp24 Commonly known as: EFFEXOR XR	Michael Gillan DR, Guthrie Clinic	Anxiety/Depression

(3368) Section 8 - Medical Treatment

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled:**

8.A. For any **physical** condition(s)?

Yes

8.B. For any **mental** condition(s) (including emotional or learning problems)?

Yes

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

Tell us who may have medical records about any of your physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		James Freeman DR					
<div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 204 of 1112</div> <div>EXHIBIT NO. B1E</div> <div>PAGE: 6 OF 11</div>							
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-888-5858		Patient ID# (if known)		340616	
Mailing Address		1 GUTHRIE SQUARE SAYRE, PA 18840					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	12/12/2008	A.		A. Date in		Date out	
Last Visit	02/27/2019	B.		B. Date in		Date out	
Next scheduled appointment (if any)	7/10/2019	C.		C. Date in		Date out	
What medical conditions were treated or evaluated?							
Rheumatoid Arthritis; Drug Induced Lupus							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Medication							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test				Dates of Tests			
Blood test (Not HIV)				10/10/2018			

8.D. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		Michael Georgetson DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852		Patient ID# (if known)		340616	
Mailing Address		1 GUTHRIE SQUARE SAYRE, PA 18840					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	11/15/2018	A.		A. Date in		Date out	
Last Visit	11/15/2018	B.		B. Date in		Date out	
Next scheduled appointment (if any)	unknown	C.		C. Date in		Date out	200

What medical conditions were treated or evaluated? Case 6:21-cv-06189-LGF Document 18 Filed 02/27/23 Page 205 of 1112 Crohn's Disease Dr. Georgetson also prescribed the following: cyanocobalamin 1000 MCG/ML Sublingual Injection Low Blood Count Probiotic Product (VSL#3) Oral Cap- Digestion							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Medication							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test				Dates of Tests			
Blood test (Not HIV)				11/14/2017			
MRI/CT Scan (Abdomen)				06/22/2019			
8.E. Name of Facility or Office Guthrie Clinic							
Name of health care professional who treated you		Michael Gillan DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2239		Patient ID# (if known)		340616	
Mailing Address		1 Guthrie Square Sayre, PA 18840					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	04/16/2013	A.		A. Date in		Date out	
Last Visit	04/18/2019	B.		B. Date in		Date out	
Next scheduled appointment (if any)	unknown	C.		C. Date in		Date out	
What medical conditions were treated or evaluated? Anxiety, Depression, High Blood Pressure- He is my Primary Care Doctor lisinopril 20 MG Tabs- High Blood Pressure venlafaxine 75 MG Cp24 Commonly known as: EFFEXOR XR- 2 different doses- Anxiety/Depression My most recent visit was with Dr. Gillan's NP, but he supervised the visit. Her name was Lynn Schutt, NP							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Medication, CPAP Machine (I have sleep apnea), referrals to psychologists							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test				Dates of Tests			
Blood test (Not HIV)				03/12/2018			
MRI/CT Scan (Abdomen/Pelvis)				04/29/2013			

8.F. Name of Facility or Office		EXHIBIT NO. B1E					
Name of health care professional who treated you		THOMAS J MCDONALD JR					
		PAGE: 8 OF 11					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852		Patient ID# (if known)		340616	
Mailing Address		GUTHRIE SQ DEPT OF MEDICINE GASTROENTEROLOGY 3RD LEVEL SAYRE, PA 18840-0000					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	12/12/2016	A.		A. Date in		Date out	
Last Visit	06/11/2018	B.		B. Date in		Date out	
Next scheduled appointment (if any)	06/11/2021	C.		C. Date in		Date out	
What medical conditions were treated or evaluated?							
Acid Reflux, Crohn's Disease, infectious causes, medications and inflammatory bowel disease, Chronic active ileitis; ulcer.							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Medication, Follow ups for Colonoscopies/Upper Endoscopies							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test				Dates of Tests			
Colonoscopy and Upper Endoscopy (GI Tract and Intestines)				12/12/2016			
MRI/CT Scan (Abdomen and Pelvis)				11/28/2016			

8.G. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		Preetika Sinh DR					
EXHIBIT NO. B1E PAGE: 9 OF 11							
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852		Patient ID# (if known)		340616	
Mailing Address		1 Guthrie Square SAYRE, PA 18840					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	06/03/2016	A.		A. Date in		Date out	
Last Visit	06/02/2017	B.		B. Date in		Date out	
Next scheduled appointment (if any)	Dr went to Cleveland	C.		C. Date in		Date out	
What medical conditions were treated or evaluated?							
I have had multiple Colonoscopies/Upper Endoscopies and multiple lab testing with Dr. Preetika Sinh Colonoscopy and Upper Endoscopy dates June 2, 2017 and December 12, 2016 Dr. Preetika Sinh has left the Guthrie Clinic and returned to the Cleveland Clinic in Ohio							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Medication- Remicade and Humira- I had an allergic reaction to Remicade and Humira caused Drug Induced Lupus							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test				Dates of Tests			
Blood test (Not HIV)				08/08/2017			
MRI/CT Scan (Abdomen and Pelvis)				05/18/2017			

8.H. Name of Facility or Office		ROBERT PACKER HOSPITAL					
Name of health care professional who treated you		Dr. Raftis				EXHIBIT NO. B1E PAGE: 10 OF 11	
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-4336		Patient ID# (if known)		340616	
Mailing Address		MEDICAL RECORDS 1 GUTHRIE SQ SAYRE, PA 18840-0000					
Dates of Treatment							
1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit		A.	05/26/2018	A. Date in	06/10/2013	Date out	06/11/2013
Last Visit		B.		B. Date in	12/14/2014	Date out	12/15/2014
Next scheduled appointment (if any)		C.		C. Date in		Date out	
What medical conditions were treated or evaluated?							
Ovarian Cyst							
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)							
Pain medication							
Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.							
Check this box if no tests by this provider or at this facility.							
Kind of Test					Dates of Tests		
Blood test (Not HIV)					05/26/2018		
MRI/CT Scan (Abdomen and Pelvis)					05/26/2018		

(3368) Section 9 - Other Medical Information

9. Does anyone else have medical information about any of your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11.)

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

EXHIBIT NO. B1E

PAGE: 11 OF 11

(3368) Section 10 - Vocational Rehabilitation, Employment, or Other Support Services**10.A.** Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An individualized education program (IEP) through a school (if a student age 18 - 21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

(3368) Section 11 - Remarks

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

My job as a Supervisor caused a lot of stress, which in turn causes me to have medical problems- diarrhea, nausea, acid reflux. I can no longer sit for long periods of time or stand for any amount of time. I can no longer spend an entire day typing, multi-tasking, keeping track of schedules- I lose concentraion, brain fog, and fatigue. I have an Associate's Degree for a Medical Secretary and can no longer do this.

Date Report Completed	 <div style="display: inline-block; text-align: center;"> <div>____/____/____</div> <div>(Month) (Day) (Year)</div> </div>
------------------------------	---

(3367) ID/Prior Filings**Identifying Information**

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Jennifer Lyn BrownHis or Her Social Security Number(s): **132-58-2507**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**Date of Birth: **10/26/1976**2. Claimant's Alleged Onset Date: **06/19/2019**3. Potential Onset Date: **06/19/2019, DIB**

4. Reason for Potential Onset Date:

SSI Application Date: **No**Date Last Insured: **No**Date First Insured: **No**Controlling Date: **No**Work Before/After AOD: **No**UWA: **No**SGA: **No**Not SGA: **No**823 In File: **No**Other (Explain Below): **Yes**5. Explanation for Potential Onset Date, when applicable: **The POD is equal to the AOD. The NH stopped working on 05/23/19 because of shoulder surgery, but does not believe this is her onset date.****Miscellaneous Information**

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case): **12/31/2023**

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case: **No****Prior Filing Information**7. Prior Filing(s): **Yes**

If "Yes" and you are not sending the prior folder, enter the following:

Type of prior claim(s):	DIB
SSN(s) of prior claim(s):	132-58-2507 HA
Date and level of last decision:	10/22/2015 Hearing
Last Decision:	Denial
Location of prior folder:	CEF
Prior folder requested:	No
Date requested:	

Type of prior claim(s):	DI
SSN(s) of prior claim(s):	132-58-2507 DI
Date and level of last decision:	10/29/2014 Initial
Last Decision:	Denial
Location of prior folder:	CEF
Prior folder requested:	No
Date requested:	

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **Teleclaim with claimant**

If the claimant had difficulty with the following, explain in Observations, or show "No" or "Not observed/perceived." (Explain any "No" answers that you think would assist the DDS in making a decision):

Hearing: **Not observed/perceived**
Reading: **Not observed/perceived**
Breathing: **Not observed/perceived**
Understanding: **Not observed/perceived**
Coherency: **Not observed/perceived**
Concentrating: **Not observed/perceived**
Talking: **Not observed/perceived**
Answering: **Not observed/perceived**

Other (specify):

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

EXHIBIT NO. B2E
PAGE: 3 OF 3

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

An employer verification letter indicating the NH's last day of work and/or proof of a SWP is pending. This will be scanned into eView upon receipt.

Name of Interviewer: **M. Jenkins**

Phone Number: **866-226-2306**

Name of Person Completing Form: **M. Jenkins**

Date: **06/27/2019**

Form SSA-3367 EDCS

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FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions (including your symptoms) limit your activities

SECTION A - INFORMATION ABOUT THE DISABLED PERSON

Daytime Telephone Number with area code. If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.

Check if this is:

☒ Your number ☐ Message number ☐ No phone available

Person Completing Form (other than the disabled person.)

Name: **Self** Relationship:

Phone number with area code: **607-215-0584**

Give the name of a friend or relative that we can contact (other than your doctor) who knows about your illnesses, injuries, or conditions and can help with your claim.

Name: **Jonathan Foote** Relationship: **Boyfriend**

Phone number with area code: **607-215-0584**

Complete address:

**141 Main St. Lot 429
Wellsburg, NY 14894**

Where do you live? (Check one)

☐ House ☐ Apartment ☐ Boarding house ☐ Nursing home
☐ Shelter ☐ Group home ☒ Other (Explain)

mobile home

With whom do you live? (Check one)

☐ Alone ☐ With family ☒ With friends

SECTION B - INFORMATION ABOUT YOUR DAILY ACTIVITIES

Describe what you do from the time you wake up until you go to bed.

Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?

☐ Yes ☒ No If "Yes", for whom do you care, and what do you do for them?

Do you take care of pets or other animals?

☒ Yes ☐ No If "Yes", what do you do for them?

Let them outside, feed them

Does anyone help you care for these people or animals?

☒ Yes ☐ No If "Yes", who helps you, and what do they help you do?

my boyfriend, let them outside, feed them, change water, keep them away from me so I can rest

What were you able to do before your illnesses, injuries, or conditions that you cannot do now?

Type for long periods of time Concentrate easier

Write for long periods of time not spend so much

Do your illnesses, injuries, or conditions affect your sleep?

☒ Yes ☐ No If "Yes", how?

Pain causes me to wake up, toss and turn, can't get comfortable

PERSONAL CARE

(Check here ☐ if no problem with personal care.)

Explain how your illnesses, injuries, or conditions affect your ability to:

Dress - some days my boyfriend helps me with my undergarments because I hurt

Bathe - N/A

Care for hair - some days my boyfriend brushes my hair because my arms

ache
Shave - N/A

Feed yourself - N/A

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Use the toilet - N/A

Other

Do you need any special help or reminders to take care of your personal needs and grooming?

☐ Yes ☒ No If "Yes", what type of help or reminders do you need?

Do you need help or reminders taking medicine?

☒ Yes ☐ No If "Yes", what kind of help do you need?

I have a reminder container for pills and my boyfriend reminds me.

MEALS

If you fix or prepare your own food or meals, what kind do you prepare?

A lot of crockpot meals, easy, no fuss

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

daily

If you do not prepare your own food or meals, explain why not.

Who prepares your food or meals?

myself or boyfriend

Describe any changes in your cooking habits since your illnesses, injuries, or conditions began.

I used to be able to spend hours baking, canning, etc. Now I need help, I get too fatigued, or I cannot eat it, gives me diarrhea

HOUSE AND YARD WORK

List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

Do you need help doing these things?

☒ Yes ☐ No If "Yes", what help do you need?

Carrying laundry baskets

If you don't do house or yard work, explain why not.

I don't do yard work anymore -
too tiring, too hard on me, makes me ache

GETTING AROUND

How often do you go outside?

daily

If you don't go out at all, explain why not.

When you go out, how do you travel? (Check all that apply)

☐ Walk ☐ Drive a car ☒ Ride in a car ☐ Ride a bicycle
☐ Use public transportation ☐ Other (Explain)

When you go out, can you go alone?

☒ Yes ☐ No If "No", explain why you can't go out alone.

Do you have a driver's license?

☒ Yes ☐ No

If "Yes", do you drive?

☒ Yes ☐ No If you don't drive, explain why not.

SHOPPING

If you do any shopping, do you shop? (Check all that apply)

☐ In stores ☐ By phone ☐ By mail ☒ By computer

Describe what you shop for.

Groceries

How often do you shop and how long does it take you?

once a month, order groceries online
1/2 hour, too hard to walk around store,
run to bathroom

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MONEY

Are you able to:

Pay bills? ☒ Yes ☐ NoCount change? ☒ Yes ☐ NoHandle a savings account? ☒ Yes ☐ No

Has your ability to handle your money changed since your illnesses, injuries, or conditions began?

☒ Yes ☐ No -If "Yes", explain how your ability to handle money has changed.

I have made several mistakes in our checking account, forget to write down amounts, account overdraw several times because of my forgetfulness.

HOBBIES AND INTERESTS

What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

Sewing Felt Crafts, writing

How often do you do these things?

used to daily, now I don't, only a few times each season.

Describe any changes in these activities since your illnesses, injuries, or conditions began.

Using needle bothers my hands, writing for long periods bothers me, can't hold pen/pencil long periods - take breaks - pain unbearable

Social Activities

Do you spend time with others? (In person, on the phone, on the computer, etc.)

☒ Yes ☐ No If "Yes", describe the kinds of things you do with others.

just visit

How often do you do these things?

once every month

List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

none

How often do you go?

I don't - usually bothers me. Can't sit/stand for long periods at a time

Do you have any problems getting along with family, friends, neighbors, or others?

☒ Yes ☐ No If "Yes", please explain.

My anxiety gets to me. A lot of people take me too serious when actually I'm joking. I get loud.

Describe any changes in your social activities since your illnesses, injuries, or conditions began.

I have depression and anxiety - don't like to be around others like I used to, I get easily bothered.

SECTION C - INFORMATION ABOUT YOUR ABILITIES. Explain how your illnesses, injuries, or conditions affect any of the following:

Lifting - Cannot lift things like I used to - weak muscles & grip

Standing - Cannot stand for long periods of time - too difficult for my feet & knees

Walking - Cannot walk far because of feet & knees

Sitting - Cannot sit for long periods of time - rheumatoid arthritis is in my knees & feet

Climbing stairs - I can, but I avoid because of my knees/joints

Kneeling - I don't because too hard to stand up

Squatting - I don't because too hard to stand up - hard on my knees

Reaching - no problem

Using hands - Cannot use hands like I used to - Swollen fingers, joints, wrists, hands get very hot

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Seeing - no changes

Hearing - no changes

Talking - I forget a lot about what I was going to say, and I lose focus because of ADHD

Are you ☒ Right handed? ☐ Left handed?

Do you use any of the following? (Check all that apply.)

- ☐ Crutches ☐ Cane ☐ Hearing Aid ☐ Walker ☐ Brace/Splint
☐ Wheelchair ☐ Artificial Limb ☒ Glasses/Contact Lenses
☐ Artificial Voice Box ☐ Other (Explain)

Which of these were prescribed by a doctor?

Glasses/contacts

When do you need these aids? (For example, walking long distances, walking on rough ground, etc.)

to see far away

How far can you walk before you have to stop and rest?

100 yards

How long do you rest before you can continue walking?

5-10 minutes - I have difficult time going to stores, when I do, I have to rest, and be near a bathroom because I have immediate diarrhea and stomach cramping

Do you have problems paying attention?
☒ Yes ☐ No If "Yes", please explain.
 I have ADHD

Can you finish what you start? (For example, chores, reading, etc.)

☐ Yes ☒ No If "No", please explain.

No I get distracted very easily and go to something else.

Can you follow spoken instructions? ☒ Yes ☐ NoCan you follow written instructions? ☒ Yes ☐ No

Have you any problems getting along with bosses, teachers, police, landlords, or other people in authority?

☒ Yes ☐ No If "Yes", please explain.I had a hard time when I was working -
a lot of brain fog, paying attention, became a problem
with my boss.

Have you ever lost a job because of problems getting along with people?

☐ Yes ☒ No If "Yes", please explain.

How does stress or changes in schedule affect you?

Stress is absolutely a huge factor in affecting me.

Any kind of stress / change in schedule / plans makes my
RA flare + Crohn's flare

Do you have trouble remembering things?

☒ Yes ☐ No If "Yes", please explain.I have been very overwhelmed with my illnesses -
the brain fog / paying attention has affected me remembering things -
SECTION D - REMARKS I even went to my PCP for it because it's
bothersome

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the signature block below.

QUESTIONS ABOUT PAIN

When did you first have the pain?

originally - RA 12/12/08

Depression started 1/20/14

ADHD started 12/28/12

Anxiety started 10/22/10 Crohn's started
7/8/16

When did the pain first begin to affect your activities?

Dec 2018 but June 20, 2019
Kept getting worse until 7 and still is

Are you receiving medical treatment for your pain?

☒ Yes ☐ No If so, please indicate the name, address and telephone number of the doctor or clinic where you are treated.

Rheumatoid Arthritis - Dr. James Freeman

Crohn's - Dr. McDonald, Dr. Michael Georgetown, +

Dr. Preetikah Singh

Anxiety / Depression - Dr. Michael Gillan

6/23165672/9749/V139/JENNIFER L. BROWN

Lynn Schutt, NP

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Guthrie Clinic
All at1 Guthrie
Square
Sayre, PA
16860

570-888-5858

121907120000839

When did you first start taking it?

Stebra - 10/26/18 Bupropion/Wellbutrin 4/15/19
 Methotrexate - 9/26/18 Venlafaxine/Effexor XR 4/15/19
 Alprazolam/Xanax 6/20/19

Does it have any side effects?

[X] Yes [] No If so, what are they?

headache diarrhea stomach pain nausea mouth sores
 tired feeling cold symptoms dizziness causes decreased
 fatigue hair loss no driving immune system
 low blood levels

In the past, have you taken other pain medication for the pain?

[X] Yes [] No If so, why did you stop or change?

Allergic Reaction - caused rash / severe skin irritation
 Caused abdominal issues

What other things do you do or use to relieve the pain? For example, do you wear or use any devices (such as a cane or a corset) to relieve the pain or treatment? If so, please describe.

No, take tylenol, heating pad, nothing eases the pain.

What are your current daily activities? Weekly activities? (Please describe things like walking, shopping, household chores, driving, socializing, etc.)

loading dish washer

wash laundry and resting - nothing else, too exhausted

Has the pain affected your daily activities? If so, please describe what activities and how they have been affected.

Yes - I can no longer sit for long periods of time
 I was a Supervisor - have problems typing, focusing, cannot remember
 important things, became unorganized, overwhelmed, stress has caused
 Who else can tell us about your pain and how it affects your activities?

Jonathan Fook, Boyfriend
 Doris Evans, mother

flares,
 fatigued, need
 to also be in the
 restroom a lot

QUESTIONS ABOUT ANXIETY

When did your condition begin? Please describe any increase/decrease in symptoms over time.

Anxiety began in and became worse in Dec 2018 when I lost
 my dad, lost my Grandma Feb 2019, stress became unbearable at work -
 trying to manage staff, take care of patients. I had surgery on shoulder in
 what triggers, or brings on the panic attacks? (For example, a situation, event, person, memory, etc.)

Traumatic loss of dad, memories, work - my manager -
 employees

June and
 May 2019
 Anxiety was
 through the
 roof - became
 worse June 2019

Have you ever had special tests to evaluate your pain?

[☒] Yes [] No If so, please indicate when and the name and address of where the evaluation was done.

Lab tests - multiple CT scans

Colonoscopies - multiple All at Guthrie Clinic
& Upper Endoscopies and Robert Packer Hospital

What does the pain feel like? Please describe. (For example, is it dull, "stabbing", an "ache", etc.)

Guthrie
Square
Sayre, PA
18840

Pain for RA is a aching, burning, very hot feeling - like you could boil an egg in my hands

Crohn's - urgency to go Bathroom, diarrhea, Cramps
Where do you feel the pain? Please state exactly where the pain is located.

RA - hands, fingers, wrists, elbows, hips, + Knees, and feet

Crohn's - bowels, stomach, acid reflux

Does it spread (radiate) to other places?

[☒] Yes [] No If so, please describe where.

throughout entire body for both

Since you first experienced the pain, has it changed in how it feels or the part of the body where you feel it? Please describe.

Yes, used to be only my feet for RA
and for Crohn's I have abdominal pain, diarrhea, bloating,
cramping, rectal bleeding

How often do you get the pain?

RA - Constant - never ending

Crohn's - when I have flare - eat something that doesn't agree with me.

What activities bring on pain?

Everything I do - no matter what I do, I have pain

How long does it last?

All the time - constant

Are you taking any medication for the pain?

[☒] Yes [] No If so, please answer the following:

What is the medication called?

Methotrexate - 50 mg

Stelara - 90 mg

(ustekinumab)

Alprazolam .25 mg (Xanax)

Bupropion 300mg (Wellbutrin)

Venlafaxine 75 mg (Effexor XR) and 150mg

What is the dosage and how often do you take it?

Methotrexate - @ 50 mg injection 1x week

Stelara - 90mg inj. every 8 wk

Bupropion 300mg 1x day

Venlafaxine 225mg 2x day

Alprazolam - .25 mg 1 tab 3x day

How soon does it relieve the pain and for how long?

It doesn't relieve pain for

6/23165672/9749/V139/JENNIFER L. BROWN

RA - Crohn's it does until a flare

121907120000839

What do you feel during a typical attack? (For example, fear, rapid heartbeat, shortness of breath, need to flee, sweating, confusion, etc.)

Confusion, fast heartbeat, shaking a lot/tremors,
sick to stomach, lightheaded

What action(s) do you take when you feel an attack coming on or happening?
(What do you do to relieve the attack?)

Sleep- Lay down

How frequently do these attacks occur? (For example, daily, weekly, monthly, every time the trigger is present?)

daily

How long do the attacks/symptoms last? (For example, immediate relief once removed from the trigger or longer?)

immediate relief once I think of something else or
different situation - Father died traumatically where I
worked (at hospital)

Are you able to travel by yourself?

yes

During an attack, are you still able to do things like shop, drive, etc.?

yes

Once the symptoms lessen, are you able to function OK or do you need to take extra time? How much time and why?

I function okay, but remain shaky
& depressed.

What is the name of your doctor for this condition and what, if any, medications do you use for this? What is the frequency of visits? Any other treatment? Do you feel the treatment you're getting helps? If not, why not?

Dr. Michael Gillan
Lynn Schutt, NP (his NP)

Has this problem resulted in any difficulties in socializing with other people?

yes - I no longer want to deal
with people or be around them

Anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under federal law.

SIGNATURE

DATE

Jennifer Lynn Brown

July 4, 2019

121907120000839



JENNIFER L. BROWN
14 MAIN ST LOT 429
WELLSBURG, NY 14894

IMPORTANT

**YOU MUST RETURN THIS SHEET WITH
ANY INFORMATION YOU SEND TO US.**

**PLEASE NOTE: IF THE ATTACHED LETTER
INCLUDES PAPERWORK THAT NEEDS TO
BE COMPLETED AND RETURNED, YOU
MUST USE THIS SHEET AS A COVER
SHEET. FAILURE TO DO SO, MAY RESULT
IN SIGNIFICANT DELAYS IN PROCESSING
YOUR CLAIM FOR DISABILITY BENEFITS.**

**A SELF ADDRESSED RETURN ENVELOPE HAS
BEEN INCLUDED FOR YOUR CONVENIENCE.**

121907120000839

—
—
JENNIFER L. BROWN
14 MAIN ST LOT 429
WELLSBURG, NY 14894

121907120000839

New York State Office of Temporary and Disability Assistance
 Division of Disability Determinations
 P.O. BOX 8783
 London, KY 40742-9927
 Phone: 1-518-626-3238 Toll Free: 1-800-522-5511 Ext. 3238 Fax: 1-866-323-8335

Date: July 1, 2019

JENNIFER L. BROWN
 14 MAIN ST LOT 429
 WELLSBURG, NY 14894

Case: 239903786

This office is responsible for obtaining information in connection with an application for or review of Social Security Disability benefits for the above named individual.

Please complete the enclosed forms and return to me in the enclosed envelope. Please make sure to follow instructions provided below when completing work history questionnaire. Thank you.

Work History Instructions:

- **For each job, please describe in detail what you did from the time you got to work until you left. Explain how each duty was completed.**
- **List what tools, machines, and equipment you used at each job.**
- **Be specific as to what you had to lift or carry for each job. What did you lift and carry and how far? Etc.**
- **If you were a supervisor, please be specific as to what your supervisor duties were.**

Please see below for an example of how the hours for an 8-hour job may be completed:

Please do not write, "Varied" or "it depends", as this will only result in a delay of the processing of your claim. Use your best judgment to determine these hours based on an average workday. Again, specific numbers are required.

EXAMPLE: (Walk + Stand + Sit = 8)

Walk? 2/8 Stand? 4/8 Sit? 2/8 (Based on 8 Hour Shift)

Please use the following terms to describe tasks such as:

Climb, Stoop, Kneel, Crouch, Crawl, Handle, Reach, Write

Frequently: You engaged in this task from 1/3 to 2/3 of your day.

Occasionally: You engaged in this task up to 1/3 of your day.

Constantly: You engaged in this task for greater than 2/3 of day.

Failure to respond to this letter within 10 days may result in a determination based on the evidence in file and this may not be to your advantage.

If you require assistance or have any questions, please contact me at the telephone number above.

Ésta es una carta muy importante. Por favor, léala cuidadosamente. Si no puede leer inglés, por favor llévesela a alguien que se la pueda leer de inmediato, o comuníquese con la Administración del Seguro Social para recibir ayuda gratis.

Sincerely yours,

K. Richardson
Disability Analyst Unit – V139

Attachments: Work History, Activities of Daily Living, Pain, Anxiety

PLEASE KEEP THIS COVER LETTER FOR YOUR RECORDS.

121907120000839

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0578

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last) JENNIFER L. BROWN	B. SOCIAL SECURITY NUMBER 132-58-2507
C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.) (607) 215 - 0584 <input checked="" type="checkbox"/> Your Number <input type="checkbox"/> Message Number <input type="checkbox"/> None Area Code Phone Number	

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

Job Title	Type of Business	Dates Worked	
		From	To
1. Supervisor Office Operations	medical office/ Hospital	October 2018	June 2019
2. Lead-Gastroenterology	medical office/ Hospital	Sept 2017	Oct. 2018
3. Patient Specialist	medical office/ Hospital	May 2015	Sept 2017
4. Point of Service Specialist Lead	medical office/ Hospital	Jan 2000	Nov 2014
5.			
6.			
7.			
8.			
9.			
10.			

Form SSA-3369-BK (04-2014) ef (04-2014)
Destroy Prior Editions

PAGE 1

Work History Report - Form SSA-3369-BK

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1		Supervisor Office Operations	
Rate of Pay	Per (Check One)	Hours per day	Days per week
\$ <u>20.97</u>	<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<u>8</u>	<u>40</u>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Typed, answered phone, time cards, interviewed, reprimanded staff, data entry, ordered, prepared offices for doctors arriving, scheduled colonoscopies / upper endoscopy procedures, took care of 17 employees

In this job, did you:

Use machines, tools, or equipment?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? <u>8</u>	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? <u>8</u>
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? <u>8</u>

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

I only lifted paper boxes

Check the **heaviest** weight lifted:

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☒ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? 17What part of your time was spent supervising people? 8 hrsDid you hire and fire employees? ☒ YES ☐ NOWere you a lead worker? ☒ YES ☐ NO

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Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2 <u>Lead - Gastroenterology</u>		Hours per day	Days per week
Rate of Pay	Per (Check One)	<u>8</u>	<u>40</u>
\$ <u>14.97</u>	<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Typed all day, answered phones, data entry all day,
trained staff, ran reports

In this job, did you:

Use machines, tools, or equipment?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? <u>8</u>	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? <u>8</u>
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? <u>8</u>

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

I only lifted paper boxes

Check the **heaviest** weight lifted:

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☒ NO (Skip to the last question on this page.)

How many people did you supervise? 0What part of your time was spent supervising people? 0Did you hire and fire employees? ☐ YES ☒ NOWere you a lead worker? ☒ YES ☐ NO

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3 <u>Patient Specialist Gastroenterology</u>		Hours per day	Days per week
Rate of Pay	Per (Check One)	<u>8</u>	<u>40</u>
\$	<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

answered phone; triaged calls; data entry all day,
sorted mail, filed

In this job, did you:

Use machines, tools, or equipment?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? <u>8</u>	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? <u>8</u>
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? <u>8</u>

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

I only lifted paper boxes

Check the **heaviest** weight lifted:

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☒ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NOWere you a lead worker? ☐ YES ☒ NO

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Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4 Point of Service Specialist Lead

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$	<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<u>8</u>	<u>40</u>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Ran reports, trained staff, monitored work, audits,
answered phones, charge entry all day

In this job, did you:

Use machines, tools, or equipment?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? <u>8</u>	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? <u>8</u>
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? <u>8</u>

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Paper boxes but they were full of reports

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☒ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☒ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? 32What part of your time was spent supervising people? 8Did you hire and fire employees? ☒ YES ☐ NOWere you a lead worker? ☒ YES ☐ NO

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$ _____	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? _____
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:
☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____
Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)
☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NOWere you a lead worker? ☐ YES ☐ NO

121907120000839

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES <input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? _____
Stoop? (Bend down & forward at waist) _____	Reach? _____
	Write, type, or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:
☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____
Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)
☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees?

☐ YES☐ NO

Were you a lead worker?

☐ YES☐ NO

SECTION 3 - REMARKS

Use this section to add any information you did not have space for in other parts of the form. Show the page number of the part you are continuing.

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

Name of person completing this form if other than the disabled person
(Please print)

Jennifer Lyn Brown

Date (Month, day, year)

07/04/2019

Address (Number and Street)

14 Main Street Lot 429

Email address (optional)

jenlyn9598@yahoo.com

City

Wellsburg

State

NY

ZIP Code

14894

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination of eligibility for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled, Claims Folders Systems; and, 60-0090, entitled, Master Beneficiary Record. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 1 hour to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

121907120000839

WORK HISTORY REPORT- Form SSA-3369-BK**READ ALL OF THIS INFORMATION BEFORE
YOU BEGIN COMPLETING THIS FORM****IF YOU NEED HELP**

If you need help with this form, complete as much of it as you can. Then call the phone number provided on the letter sent with the form or the phone number of the person who asked you to complete the form for help to finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Print or type.
- A reference to "you," "your," or "the Disabled Person," or "claimant" means the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- **ANSWER ALL OF THE QUESTIONS FOR EACH JOB YOU DESCRIBE.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. The information tells us about the kinds of work you did, including the types of skills you needed and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different jobs you did in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. There is a separate page to describe each different job.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Work History Report -- Form SSA-3369-BK

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use this information to process the named claimant's claim.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the named claimant's claim.

We rarely use this information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigatory activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act Systems of Records Notices entitled, Claims Folders Systems, 60-0089, and Electronic Disability (eDib) Claim File, 60-0320. These notices, additional information regarding our programs and systems, are available online at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 61 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.***

**PLEASE REMOVE THIS SHEET BEFORE RETURNING
THE COMPLETED FORM.**

061907120002947

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0635**FUNCTION REPORT - ADULT - THIRD PARTY***How the disabled person's illnesses, injuries, or conditions limit his/her activities***SECTION A - GENERAL INFORMATION**

1. NAME OF DISABLED PERSON (First, Middle, Last)

JENNIFER L. BROWN

2. YOUR NAME (Person completing the form)

JONATHAN G. FOOTE

3. RELATIONSHIP
(To disabled person)

BOYFRIEND

4. DATE (Month, Day, Year)

7/8/2019

5. YOUR DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

(607) 215-0584
Area Code Phone Number☒ Your Number☒ Message Number☐ None

6. a. How long have you known the disabled person? 35+ YEARS

b. How much time do you spend with the disabled person and what do you do together?

24/7, LIVE TOGETHER

7. a. Where does the disabled person live? (Check one.)

☒ House☐ Apartment☐ Boarding House☐ Nursing House☐ Shelter☐ Group Home☐ Other (What?)

b. With whom does he/she live? (Check one.)

☐ Alone☐ With Family☒ With Friends☐ Other (describe relationship)**SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS**

8. How do this person's illnesses, injuries, or conditions limit his/her ability to work?..

CAN'T SET FOR LONG PERIODS OF TIME CONSTANTLY GOING TO
BATHROOM, HARD TO USE HANDS FOR DAILY THINGS

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

RESTING AND SLEEPING

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?

☐ Yes☒ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals?

☒ Yes☐ NoIf "YES," what does he/she do for them? FEED THEM, LET THEM OUT IN FENCED YARD

12. Does anyone help this person care for other people or animals?

☒ Yes☐ NoIf "YES," who helps, and what do they do to help? MYSELF ... FEED, WATER, LET OUT, LETTER BOXES

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

☐ Yes☐ NoBAKE AND COOK, DESIGNED FOR LONG PERIODS OF TIME, NO CRAFTS, CAN'T TYPE

14. Do the illnesses, injuries, or conditions affect his/her sleep?

☒ Yes☐ NoIf "YES," how? STRESS & ANXIETY KEEPS UP, PAIN MAKES Toss & TURN15. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress SLOWER, NEEDS HELPBathe —Care for hair I BRUSH HAIRShave —Feed self —Use the toilet —Other —

061907120002947

- b. Does he/she need any special reminders to take care of personal needs and grooming?

☒ Yes ☐ No

If "YES," what type of help or reminders are needed?

FORGETFUL

- c. Does he/she need help or reminders taking medicine?

☒ Yes ☐ No

If "YES," what type of help does he/she need?

I REMIND AND USES PILL ORGANIZER

16. MEALS

- a. Does the disabled person prepare his/her own meals?

☒ Yes ☐ No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

CROCKPOT

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

DAILY

How long does it take him/her?

LONGER THAN USED TO

Any changes in cooking habits since the illness, injuries, or conditions began?

NOT AS MUCH

- b. If "No," explain why he/she cannot or does not prepare meals.

17. HOUSE AND YARD WORK

- a. List household chores, both indoors and outdoors, that the disabled person is able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

NO OUTDOOR THINGS

SOME LAUNDRY

- b. How much time do chores take, and how often does he/she do each of these things?

ALL DAY FOR FEW LOADS OF LAUNDRY

- c. Does he/she need any special reminders to take care of personal needs and grooming?

☒ Yes ☐ No

If "YES," what help is needed?

FORGETFUL

d. If the disabled person doesn't do house or yard work, explain why not.

YARD WORK IS TOO STRENUOUS AND WEATHER CONDITIONS

18. GETTING AROUND

a. How often does this person go outside?

DAILY
If he/she doesn't go out at all, explain why not.

b. When going out, how does he/she travel? (Check all that apply.)

☒ Walk☐ Drive a car☒ Ride in a car☐ Ride a bicycle☐ Use public transportation☐ Other (Explain)

c. When going out, can he/she go out alone?

☒ Yes☐ No

If "NO," explain why he/she can't go out alone.

d. Does the disabled person drive?

☒ Yes☐ No

If he/she doesn't drive, explain why not.

BUT RARELY

19. SHOPPING

a. If the disabled person does any shopping, does he/she shop: (Check all that apply.)

☐ In stores☐ By phone☐ By mail☒ By computer

b. Describe what he/she shops for.

HOUSEHOLD & GROCERIES

c. How often does he/she shop and how long does it take?

ONCE A MONTH

20. MONEY

a. Is he/she able to:

Pay bills

☒ Yes☐ No

Handle a savings account

☒ Yes☐ No

Count change

☒ Yes☐ No

Use a checkbook/money orders

☒ Yes☐ No

Explain all "NO" answers.

CHECKBOOK ALWAYS WRONG

061907120002947

- b. Has the disabled person's ability to handle money changed since the illnesses, injuries, or conditions began?

☒ Yes ☐ No

If "YES," explain how the ability to handle money has changed. CHECKBOOK INCORRECT
AND VERY FORGETFUL

21. HOBBIES AND INTERESTS

- a. How are his/her hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

PRETTY MUCH JUST TV NOW, NO INTEREST

- b. How often and how well does he/she do these things? DAILY

- c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

THEY HAVE DISAPPEARED

22. SOCIAL ACTIVITIES

- a. Does the disabled person spend time with others? (In person, on the phone, on the computer, etc.)

☒ Yes ☐ No

If "YES," describe the kinds of things he/she does with others. ON PHONE

How often does he/she prepare do these things? —

- b. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.)

MOM'S HOUSE

Does he/she need to be reminded to go places?

☒ Yes ☐ No

How often does he/she go and how much does he/she take part? WHENEVER NEEDED

Does he/she need someone to accompany him/her?

☐ Yes ☒ No

c. Does this person have any problems getting along with family, friends, neighbors, or others?

☒ Yes ☐ No

If "YES", explain. NEIGHBORS AND SOME FAMILY

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

STAYS TO SELF

SECTION D - INFORMATION ABOUT ABILITIES

23. a. Check any of the following items the disabled person's illnesses, injuries, or conditions affect:

- | | | | |
|---|--|--|---|
| <input checked="" type="checkbox"/> Lifting | <input checked="" type="checkbox"/> Walking | <input checked="" type="checkbox"/> Stair Climbing | <input checked="" type="checkbox"/> Understanding |
| <input checked="" type="checkbox"/> Squatting | <input checked="" type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input checked="" type="checkbox"/> Kneeling | <input checked="" type="checkbox"/> Memory | <input checked="" type="checkbox"/> Using Hands |
| <input checked="" type="checkbox"/> Standing | <input checked="" type="checkbox"/> Talking | <input checked="" type="checkbox"/> Completing Tasks | <input checked="" type="checkbox"/> Getting Along with Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input checked="" type="checkbox"/> Concentration | |

Please explain how his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

b. Is the disabled person: ☒ Right Handed? ☐ Left Handed?

c. How far can he/she walk before needing to stop and rest? 100 YARDS

If he/she has to rest, how long before he/she can resume walking? COUPLE MINUTES

d. For how long can the disabled person pay attention? NOT LONG

e. Does the disabled person finish what he/she starts? (For example, a conversation, a chore, reading, watching a movie.)

☐ Yes ☒ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

POOR

g. How well does the disabled person follow spoken instructions? CAN'T REMEMBER THINGS

0619071200002947

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.)

OK

i. Has he/she ever been fired or laid off from a job because of problems getting along with other people?

☐ Yes☒ No

If "YES", please explain.

If "YES", please give name of employer.

j. How well does the disabled person handle stress? NOT WELL @ ALL

k. How well does he/she handle changes in routine? GETS CONFUSED

l. Has you noticed any unusual behavior or fears in the disabled person?

☐ Yes☒ No

If "YES", please explain.

23. Does the disabled person use any of the following (Check all that apply.)

☐ Crutches☐ Cane☐ Hearing Aid☐ Walker☐ Brace/Splint☒ Glasses/Contact Lenses☐ Wheelchair☐ Artificial Limb☐ Artificial Voice Box☐ Other (Explain)

Which of these were prescribed by a doctor? GLASSES

When was it prescribed? AS A CHILD

When does this person need to use these aids? 24/7

10. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions?

☒ Yes

☐ No

If "YES," do any of the medicines cause side effects?

☒ Yes

☐ No

If "YES," please explain. (Do not list all the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS
- ALPARGOLAM	DROWSY
- BUPROPION	DROWSY, FATIGUE
- VENAFLOXINE	NAUSEA, HEADACHE
- USTEKINUMAB (STELARA)	HEADACHE, TIREDNESS

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

- METHOTREXATE ... HAIR LOSS, DIZZY, NAUSEA
 - CYCLOBENZAPRINE ... DROWSY
 - LISINAPREL ... DIZZY, DIARRHEA

Name of person completing this form (Please print)

JONATHAN G. FOTE

Date (month, day, year)

7/8/2019

Address (Number and Street)

14 MAIN ST. LOT # 429

Email address (optional)

City

WELLSBURG

State

NY

Zip Code

14894

061907120002947



061907120002947

E30

Jonathan George Foote
14 Main St Lot 429
Wellsburg, NY 14894

IMPORTANT

**YOU MUST RETURN THIS SHEET WITH
ANY INFORMATION YOU SEND TO US.**

**PLEASE NOTE: IF THE ATTACHED LETTER
INCLUDES PAPERWORK THAT NEEDS TO
BE COMPLETED AND RETURNED, YOU
MUST USE THIS SHEET AS A COVER
SHEET. FAILURE TO DO SO, MAY RESULT
IN SIGNIFICANT DELAYS IN PROCESSING
YOUR CLAIM FOR DISABILITY BENEFITS.**

**A SELF ADDRESSED RETURN ENVELOPE HAS
BEEN INCLUDED FOR YOUR CONVENIENCE.**

061907120002947

New York State Office of Temporary and Disability Assistance

Division of Disability Determinations

P.O. BOX 8783

London, KY 40742-9927

Phone: 1-518-626-3238 Toll Free: 1-800-522-5511 Ext. 3238 Fax: 1-866-323-8335

Date: July 1, 2019

Jonathan George Foote

14 Main St Lot 429

Wellsburg, NY 14894

Re: JENNIFER L. BROWN

Case: 239903786

This office is responsible for obtaining information in connection with an application for or review of Social Security Disability benefits for the above named individual.

The above-named provided your name and contact information as someone who can assist with his/her claim for disability. Please complete the enclosed forms and return in the envelope provided. Thank you.

If you require assistance or have any questions, please contact me at the telephone number above.

Ésta es una carta muy importante. Por favor, léala cuidadosamente. Si no puede leer inglés, por favor llévesela a alguien que se la pueda leer de inmediato, o comuníquese con la Administración del Seguro Social para recibir ayuda gratis.

Sincerely yours,

K. Richardson

Disability Analyst Unit – V139

Attachments: 3rd Party ADL

PLEASE KEEP THIS COVER LETTER FOR YOUR RECORDS.

061907120002947

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-BK

**READ ALL OF THIS INFORMATION BEFORE
YOU BEGIN COMPLETING THIS FORM**

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Function Report - Adult - Third Party Form SSA-3380-BK

DISABILITY WORKSHEET

EXHIBIT NO. B6E

PAGE: 1 OF 9

DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
JENNIFER BROWNFULL A/N/BIC
132-58-2507
/
ASSIGNED TO /PIN
K RICHARDSON
/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

TREATING SOURCE SUMMARY

TREATING SOURCE NAME: DISPOSITION

THOMAS J MCDONALD, MD	report was received and is in file.
ROBERT PACKER HOSPITAL	report was received and is in file.
MICHEAL GEORGETSON, MD	

JAMES FREEMAN, MD	report was received and is in file.
MICHAEL GILLAN, DO	report was received and is in file.
PREETIKA SINH, MD	report was received and is in file.
LYNN SCHUTT, FNP	did not respond to our requests.

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
01	ROBERT PACKER/S /3880		07/01/19			C
	GENERATION COMP (A/F SEL)		07/01/19			
	FU/ROBERT PACKER/S /3880		07/08/19			
	GENERATION COMP (A/F)		07/08/19			
02	ROBERT PACKER/FAX/3880		07/01/19			C
	GENERATION COMP (A/F SEL)		07/01/19			
	10:01A SENT OK 5708875153		07/01/19			
	FU/ROBERT PACKER/FAX/3880		07/08/19			
	GENERATION COMP (A/F)		07/08/19			

EDP CLOSURE INPUT DATA

EOR - [X] YES [] NO CE - [X] YES [] NO DEC - [] AL [] DE [] CO NOTICE - [] YES [] NO
[] CE [] CP [] ND

[] RECON AFF. [] RECON REV. TEC.REV.DATE _____ EDP INPUT _____

DST C25 [] OVR [] DCP [] VRS [] NO VR EDP DIARY _____

SPECIAL ROUTING _____ 408 COMMENTS _____

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DISABILITY WORKSHEET

EXHIBIT NO. B6E
PAGE: 2 OF 9DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
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ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	IMAGE RECEIVD ON 07/12/19		07/12/19			
	REP,VOUCH RECD: PAY TO CF		07/15/19			
	CORREC/ROBERT PACKER HOSP		07/15/19	07/15/19	07/16/19	
	Report received		07/16/19			
03	THOMAS MCDONALD, /3883/S		07/01/19			C
	GENERATION COMP(A/F SEL)		07/01/19			
	FU/THOMAS MCDONALD, /3883		07/11/19			
	GENERATION COMP (A/F)		07/11/19			
	IMAGE RECEIVD ON 07/11/19		07/11/19			
	CORREC/THOMAS MCDONA/3880		07/11/19	07/11/19	07/12/19	
	REP RECD: NON-PAYMENT MER		07/11/19			
	Report received		07/12/19			
04	Clmt ADL/Clmt/		07/01/19			C
	ADL		07/01/19			
	Anxiety Questionnaire		07/01/19			
	Pain Questionnaire		07/01/19			
	Work History SSA-3869-BK		07/01/19			
	FU/3876/CLMT		07/12/19			
	FU/3876/ADTNL PTY		07/12/19			

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DISABILITY WORKSHEET

EXHIBIT NO. B6E
PAGE: 3 OF 9DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
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132-58-2507
/
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K RICHARDSON
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07/01/19

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3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	GENERATION COMPLETE		07/12/19			
	IMAGE RECEIVD ON 07/12/19		07/12/19			
	CORREC/Clmt ADL /3876		07/12/19	07/12/19	07/15/19	
	REP RECD: NON-PAYMENT MER		07/12/19			
	Report received		07/15/19			
05	Clmt ADL/3P/		07/01/19			C
	3rd Party ADL		07/01/19			
	IMAGE RECEIVD ON 07/12/19		07/12/19			
	CORREC/Clmt ADL /3875		07/12/19	07/12/19	07/15/19	
	REP RECD: NON-PAYMENT MER		07/12/19			
	Report received		07/15/19			
06	20 day follow-up		07/01/19			C
07	MICHEAL GEORGETSO/3883/S		07/08/19			C
	GENERATION COMP (A/F SEL)		07/08/19			
	FU/MICHEAL GEORGETSO/3883		07/18/19			
	GENERATION COMP (A/F)		07/18/19			
08	R/C Provider clarifn 0100		07/08/19			C
	CORREC/SSA-5002 R/C		07/08/19	07/08/19	07/08/19	
09	C25/Update After Transfer		07/12/19			C

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DISABILITY WORKSHEET**EXHIBIT NO. B6E
PAGE: 4 OF 9**DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
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1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	CORREC/SEI/Wage Verificat		07/12/19	07/12/19	07/15/19	
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	Report received		07/15/19			
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10	C25/Update After Transfer		07/13/19			C
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	CORREC/Other Updates		07/13/19	07/13/19	07/15/19	
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	Report received		07/15/19			
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11	C25/Update After Transfer		07/13/19			C
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	CORREC/5002 ROC		07/13/19	07/13/19	07/15/19	
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	Report received		07/15/19			
--	-----------------	--	----------	--	--	--

12	JAMES FREEMAN, MD/3883/S		07/23/19			C
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	GENERATION COMP(A/F SEL)		07/23/19			
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	FU/JAMES FREEMAN, MD/3883		08/02/19			
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	GENERATION COMPLETE		08/02/19			
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	IMAGE RECEIVD ON 08/29/19		08/29/19			
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	REP,VOUCH RECD: PAY TO CF		08/29/19			
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	CORREC/JAMES FREEMAN,MD		08/29/19	08/29/19	08/29/19	
--	-------------------------	--	----------	----------	----------	--

	Report received		08/29/19			
--	-----------------	--	----------	--	--	--

13	MICHAEL GILLAN /3883/S		07/23/19			C
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	GENERATION COMP(A/F SEL)		07/23/19			
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	FU/MICHAEL GILLAN /3883		08/02/19			
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DISABILITY WORKSHEET

EXHIBIT NO. B6E
PAGE: 5 OF 9DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
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132-58-2507
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K RICHARDSON
/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	GENERATION COMPLETE		08/02/19			
	IMAGE RECEIVD ON 08/19/19		08/19/19			
	REP,VOUCH RECD: PAY TO CF		08/20/19			
	CORREC/MICHAEL GILLAN,DO		08/20/19	08/20/19	08/28/19	
	Report received		08/28/19			
14	CE/MENT / /		07/23/19			C
	O&V F190VMN/DTP/INDUSTRIA		07/23/19			
	CE5-CE9-CLMT/BROWN JENNI		07/23/19			
	APPT. SCHEDULED		07/24/19			
	CORREC/CE-10 NOTES 01		07/24/19	07/24/19	07/29/19	
	CORREC/CE APPT NOTICE 01		07/25/19	07/25/19	07/29/19	
	O&V F190VMN/PROV RECEIPT		07/26/19			
	CE10R		07/26/19			
	1ST APPT 08/21/19 10:30 A					
	CLAIMANT RECEIVED PHONE REM					
	Report received		07 29 19			
	Report received		07 29 19			
	CORREC/CE APPT NOTICE 02		08 12 19	08/12/19	08/13/19	
	Report received		08 13 19			

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DISABILITY WORKSHEET

EXHIBIT NO. B6E
PAGE: 6 OF 9DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
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/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	1ST APPT. KEPT		08 21 19			
	CE10R		08 23 19			
	1ST APPT 08/21/19 10:30 A					
	CLAIMANT RECEIVED PHONE REM					
	CLAIMANT KEPT 1ST APPT					
	ALL EXAMS/TESTS COMPL. Y					
	CERTIFIED O&V F190VMN		08 27 19			
	CORREC/INDUSTRIAL MEDICIN		08 27 19	08/27/19	08/28/19	
	Report received		08 28 19			
15	CE/MUSC / /		07 23 19			C
	O&V F190VMP/DTP/INDUSTRIA		07 23 19			
	CE5-CE9-CLMT/BROWN JENNI		07 23 19			
	APPT. SCHEDULED		07 24 19			
	CORREC/CE-10 NOTES 01		07 24 19	07/24/19	07/29/19	
	CORREC/CE APPT NOTICE 01		07 25 19	07/25/19	07/29/19	
	O&V F190VMP/PROV RECEIPT		07 26 19			
	CE10R		07 26 19			
	1ST APPT 08/21/19 09:45 A					
	CLAIMANT RECEIVED PHONE REM					

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DISABILITY WORKSHEET

EXHIBIT NO. B6E
PAGE: 7 OF 9DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
JENNIFER BROWNFULL A/N/BIC
132-58-2507
/
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K RICHARDSON
/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
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	Report received		07 29 19			
	Report received		07 29 19			
	CORREC/CE APPT NOTICE 02		08 12 19	08/12/19	08/13/19	
	Report received		08 13 19			
	1ST APPT. KEPT		08 21 19			
	CE10R		08 23 19			
	1ST APPT 08/21/19 09:45 A					
	CLAIMANT RECEIVED PHONE REM					
	CLAIMANT KEPT 1ST APPT					
	ALL EXAMS/TESTS COMPL. Y					
	CERTIFIED O&V F190VMP		08 30 19			
	CORREC/INDUSTRIAL MEDICIN		08 30 19	08/30/19	09/04/19	
	Report received		09 04 19			
16	PREETIKA SINH, MD/3883/S		07 23 19			C
	GENERATION COMP(A/F SEL)		07 23 19			
	FU/PREETIKA SINH, MD/3883		08 02 19			
	GENERATION COMPLETE		08 02 19			
	IMAGE RECEIVD ON 08/07/19		08 07 19			
	REP,VOUCH RECD: PAY TO CF		08 08 19			

PAGE 7 OF 9

DISABILITY WORKSHEET**EXHIBIT NO. B6E
PAGE: 8 OF 9**DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
JENNIFER BROWNFULL A/N/BIC
132-58-2507
/
ASSIGNED TO /PIN
K RICHARDSON
/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
	CORREC/PREETIKA SINH, MD		08 08 19	08/08/19	08/13/19	
	Report received		08 13 19			
	IMAGE RECEIVD ON 08/19/19		08 19 19			
	REP,VOUCH RECD: PAY TO CF		08 20 19			
	CORREC/PREETIKA SINH, MD		08 20 19	08/20/19	08/28/19	
	Report received		08 28 19			
17	OT Psych Forms		08 28 19			C
18	DF-232/Psych 0100		08 28 19			C
	MC Adv/Assist Requested		08 28 19			
	CORREC/DF-232 Med Advice		09 05 19	09/05/19	09/05/19	
	Held until closure		09 05 19			
19	DF-232/Internal Med 0101		09 04 19			C
	MC Adv/Assist Requested		09 04 19			
	CORREC/DF-232 Med Advice		09 09 19	09/09/19	09/10/19	
	Held until closure		09 10 19			
20	LYNN SCHUTT, NP /3883/F		09 10 19			C
	GENERATION COMP(A/F SEL)		09 10 19			
	09:42A SENT OK 5708873285		09 10 19			
	FU/LYNN SCHUTT, NP /3883		09 17 19			

PAGE 8 OF 9

DISABILITY WORKSHEET**EXHIBIT NO. B6E
PAGE: 9 OF 9**DDD-4080 (rev. 3/89)
(formerly DF-203)CLAIMANT NAME:
JENNIFER BROWNFULL A/N/BIC
132-58-2507
/
ASSIGNED TO /PIN
K RICHARDSON
/9749INTAKE DATE
07/01/19

LEVEL	TITLE	TYPE	FILING DATE	CROSS REF.	REASSIGN DATE
1. IN	02	DIB	06/19/19	132-58-2507/ 000-00-0000/ MOD/UNIT V/139	
2.				DISTRICT OFFICE CODE C25	
3.					

ID. NUM.	DEVELOPMENT ACTION	FOLLOW UP DATE	DATE OF ACTION	EVIDENCE SECURED	EVIDENCE REVIEWED	STATUS
	GENERATION COMP (A/F)		09 17 19			
	07:00A SENT OK 5708873285		09 17 19			
21	V17/Update After Transfer		09 10 19			C
	CORREC/DDE		09 10 19	09/10/19	09/12/19	
	Report received		09 12 19			
22	OT Decision		09 18 19			C
23	DECISN/02/DIB		09 18 19			C
24	V17/Update After Transfer		09 18 19			C
	CORREC/DDE		09 18 19	09/18/19	09/18/19	
	Report received		09 18 19			
25	PDN DIB 1		09 18 19			C
26	SUP OK/9222		09 19 19			C
27	TR OK/9763 SENT TO LQA		09 20 19			C
28	LQA OK/3786		09 20 19			C
29	CLOSE/02/DIB \		09 20 19			C

(3367) ID/Prior Filings**Identifying Information**

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Jennifer Lyn Brown

His or Her Social Security Number(s): **132-58-2507**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**

Date of Birth: **10/26/1976**

2. Claimant's Alleged Onset Date: **06/19/2019**

3. Potential Onset Date: **06/19/2019, DIB**

4. Reason for Potential Onset Date:

SSI Application Date: **No**

Date Last Insured: **No**

Date First Insured: **No**

Controlling Date: **No**

Work Before/After AOD: **No**

UWA: **No**

SGA: **No**

Not SGA: **No**

823 In File: **No**

Other (Explain Below): **Yes**

5. Explanation for Potential Onset Date, when applicable: **AOD**

Miscellaneous Information

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case): **12/31/2023**

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If "Yes" and you are not sending the prior folder, enter the following:

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **N. Diles**

Phone Number: **866-964-1715**

Name of Person Completing Form: **N. Diles**

Date: **10/24/2019**

(3441) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last, Suffix): **Jennifer Lyn Brown**

1.B. Social Security Number: **132-58-2507**

1.C. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada:
607-215-0584

Check this box if you do not have a phone or number where we can leave a message

1.D. Alternate Phone Number - another number where we may reach you, if any: **607-483-1886**

1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last) **Jonathan Foote**

2.B. Relationship to Disabled Person **Friend/Neighbor**

2.C. Mailing Address (Street or PO Box)

Include apartment number or unit if applicable. **14 Main Street Lot 429**
City, State/Province, ZIP/Postal Code, **Wellsburg, NY 14894**
Country (if not U.S.)

2.D. Daytime Phone Number, including area code
(include IDD and country codes if outside the U.S. or Canada) **607-215-0584**

2.E. Can this person speak and understand English? **Yes**

If no, what language does the contact person prefer?

2.F. Who is completing this form? **Someone else (Please complete the information below).**

2.G. Name (First, Middle, Last) **Jonathan Paul Foster Jr**
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2.H. Relationship to Disabled Person **Appointed Representative (Attorney/Staff)** **EXHIBIT NO. B8E**
PAGE: 2 OF 10
2.I. Mailing Address (Street or PO Box)
Include apartment number or unit if applicable. **303 South Keystone Ave**
City, State/Province, ZIP/Postal Code, **Sayre, PA 18840**
Country (if not U.S.)
2.J. Daytime Phone Number, including area code
(include IDD and country codes if outside **570-888-1529**
the U.S. or Canada)

(3441) Section 3 - Medical Conditions

Date of Last disability report: **06/27/2019**

3.A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your physical or mental conditions?

Yes

Approximate date change occurred:

October 2, 2019

If "Yes", please describe in detail:

Worse pain, unable to function some days, has hard time getting up/down, hands hot, inflamed, and medications added.

3.B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions? **Yes**

Approximate date of new conditions:

July 17, 2019

If "Yes", please describe in detail:

Enteropathic Arthritis

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname.

Yes

If yes, please list the other names used here: **Jennifer Lyn Evans**

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

Physical

If you answered "Yes" to 4.B., please tell us who may have NEW medical records about any of your **physical or mental** conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

4.D. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		James Freeman DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2482 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	10/02/2019	Date		Date in		Date out	
Last Visit		Date		Date in		Date out	
Next scheduled appointment (if any)	12/11/2019	Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Rheumatoid arthritis and Enteropathic arthritis							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medication							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
No							
KIND OF TEST				DATES OF TESTS		261	
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

4.D. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		Michael Georgetson DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	July 8, 2016	Date		Date in		Date out	
Last Visit	August 2019	Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Crohn's Disease							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
Yes							
KIND OF TEST				DATES OF TESTS			
Blood Test (Not HIV)				08/26/2019			
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

4.D. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		Michael Gillan DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2239 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	08/22/2019	Date		Date in		Date out	
Last Visit		Date		Date in		Date out	

Next scheduled appointment (if any)	11/15/2019	Date		Date in		Date out	
<div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 267 of 1112</div> <div>EXHIBIT NO. B8E PAGE: 5 OF 10</div>							
What medical conditions were treated or evaluated?							
Hypertension, Depression, Impingement syndrome, left elbow pain							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
x-rays, physical therapy, and medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
Yes							
KIND OF TEST					DATES OF TESTS		
X-ray (elbow/shoulder)					08/22/19		
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							
4.D. Name of Facility or Office Guthrie Clinic							
Name of health care professional who treated you		Thomas McDonald DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	June 11, 2018	Date		Date in		Date out	
Last Visit		Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Crohn's Disease							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
No							
KIND OF TEST					DATES OF TESTS		
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

4.D. Name of Facility or Office		Guthrie Clinic		EXHIBIT NO. B8E			
Name of health care professional who treated you		Preetika Sinh DR		PAGE: 6 OF 10			
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit		Date		Date in		Date out	
Last Visit	June 2, 2017	Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Crohn's Disease							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
No							
KIND OF TEST				DATES OF TESTS			
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

(3441) Section 5 - Other Medical Information

Uslekinumab	Michael Georgetson DR, Guthrie Clinic	Crohn's Disease	Fatigue and confusion
Veraflaxine	Michael Gillan DR, Guthrie Clinic	Depression	tremor, confusion, anxiety, and drowsiness
Vitamin D3	Michael Georgetson DR, Guthrie Clinic	Crohn's Disease	none

If you need to list more medicines, use SECTION 10 - REMARKS on the last page.

(3441) Section 7 - Activities

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

Yes

If yes, please describe in detail:

Worse - having problems with more pain, sitting, standing, trying to get up, and anxiety

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed?

If yes, you will be asked to provide additional information.

No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

No

If yes, what type?

Date(s) attended:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services **EXHIBIT NO. B8E**
PAGE 9 OF 10

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 10 - Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THE ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code) 14 MAIN ST LOT 429 WELLSBURG, NY 14894	e-mail Address (optional)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

061912050002129

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions (including your symptoms) limit your activities

SECTION A - INFORMATION ABOUT THE DISABLED PERSON

Daytime Telephone Number with area code. If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.

607-215-0584

Check if this is:

☒ Your number ☒ Message number ☐ No phone available

Person Completing Form (other than the disabled person.)

Name: myself Relationship: Self
Jennifer L. Brown

Phone number with area code:

607-215-0584

Give the name of a friend or relative that we can contact (other than your doctor) who knows about your illnesses, injuries, or conditions and can help with your claim.

Name: Jonathan Foote Relationship: Boyfriend

Phone number with area code:

607-215-0584

Complete address:

14 main St. Lot 429
Wellsburg, NY 14894

Where do you live? (Check one)

☐ House ☐ Apartment ☐ Boarding house ☐ Nursing home
☐ Shelter ☐ Group home ☒ Other (Explain)
mobile home

With whom do you live? (Check one)

☐ Alone ☐ With family ☒ With friends

SECTION B - INFORMATION ABOUT YOUR DAILY ACTIVITIES

Describe what you do from the time you wake up until you go to bed.

Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?

☒ Yes ☐ No If "Yes", for whom do you care, and what do you do for them?

my mother - father passed away - I fix her dinner and give it to her.

Do you take care of pets or other animals?

☒ Yes ☐ No If "Yes", what do you do for them?

Feed them, let them out

Does anyone help you care for these people or animals?

☒ Yes ☐ No If "Yes", who helps you, and what do they help you do?

Boyfriend - lets dogs in and out and feeds them

What were you able to do before your illnesses, injuries, or conditions that you cannot do now?

Stand or sit for long periods of time, think clearly

Do your illnesses, injuries, or conditions affect your sleep?

☒ Yes ☐ No If "Yes", how?

I either lose sleep or sleep too much. I am in constant pain.

PERSONAL CARE

(Check here ☒ if no problem with personal care.)

Explain how your illnesses, injuries, or conditions affect your ability to:

Dress

Bathe

Care for hair

Shave

Feed yourself

061912050002129

Use the toilet

Other

Do you need any special help or reminders to take care of your personal needs and grooming?

☒ Yes ☐ No If "Yes", what type of help or reminders do you need?

Pill containers labeled, sticky notes, Calendars, and Boyfriend tells me.

Do you need help or reminders taking medicine?

☒ Yes ☐ No If "Yes", what kind of help do you need?

my boyfriend gives me injections and labeled pill sorter

MEALS

If you fix or prepare your own food or meals, what kind do you prepare?

mostly crock pot

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

weekly

If you do not prepare your own food or meals, explain why not.

Boyfriend does sometimes. I have a lot of pain in my hands + feet

Who prepares your food or meals?

I do or my boyfriend

Describe any changes in your cooking habits since your illnesses, injuries, or conditions began.

cannot stand/sit for long periods
too tired, hurt too much

HOUSE AND YARD WORK

List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

Do you need help doing these things?

☐ Yes ☒ No If "Yes", what help do you need?

If you don't do house or yard work, explain why not.

I do not ~~do~~ do. My boyfriend
tries or we have some friends do it.

GETTING AROUND

How often do you go outside?

Daily

If you don't go out at all, explain why not.

When you go out, how do you travel? (Check all that apply)

☐ Walk ☒ Drive a car ☒ Ride in a car ☐ Ride a bicycle
☐ Use public transportation ☐ Other (Explain)

When you go out, can you go alone?

☒ Yes ☐ No If "No", explain why you can't go out alone.

Do you have a driver's license?

☒ Yes ☐ No

If "Yes", do you drive?

☒ Yes ☐ No If you don't drive, explain why not.

SHOPPING

If you do any shopping, do you shop? (Check all that apply)

☐ In stores ☐ By phone ☐ By mail ☒ By computer

Describe what you shop for.

groceries - order online

How often do you shop and how long does it take you?

monthly - hour or longer - I take breaks

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MONEY

Are you able to:

Pay bills? ☒ Yes ☐ NoCount change? ☒ Yes ☐ NoHandle a savings account? ☒ Yes ☐ No

Has your ability to handle your money changed since your illnesses, injuries, or conditions began?

☒ Yes ☐ No If "Yes", explain how your ability to handle money has changed.

I have brain fog. I cannot do math well at all.
I make mistakes a lot in the checking account.

HOBBIES AND INTERESTS

What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

watching tv

How often do you do these things?

daily in evening

Describe any changes in these activities since your illnesses, injuries, or conditions began.

I cannot watch for long periods like
I used to.

Social Activities

Do you spend time with others? (In person, on the phone, on the computer, etc.)

☐ Yes ☒ No If "Yes", describe the kinds of things you do with others.

How often do you do these things?

N/A

List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

N/A - I don't

How often do you go?

Do you have any problems getting along with family, friends, neighbors, or others?

[] Yes [✓] No If "Yes", please explain.

Describe any changes in your social activities since your illnesses, injuries, or conditions began.

cannot go out - don't feel good,
exhausted a lot

SECTION C - INFORMATION ABOUT YOUR ABILITIES

Explain how your illnesses, injuries, or conditions affect any of the following:

Lifting - cannot lift anything heavy

Standing - cannot stand for long periods

Walking - cannot walk for

Sitting - cannot sit for long periods

Climbing stairs - stairs hurt my knees

Kneeling - cannot kneel - hurts knees

Squatting - can only squat with help

Reaching - I can reach, but cannot keep arms lifted long

Using hands - hands hurt, burn, cannot write type for long - they get very hot

061912050002129

Seeing - no changes

Hearing - no changes

Talking - ~~at~~ I forget a lot, Brain fog,
can't remember, get confused

Are you ☒ Right handed? ☐ Left handed?

Do you use any of the following? (Check all that apply.)

☐ Crutches ☐ Cane ☐ Hearing Aid ☐ Walker ☐ Brace/Splint
☐ Wheelchair ☐ Artificial Limb ☒ Glasses/Contact Lenses
☐ Artificial Voice Box ☐ Other (Explain)

Which of these were prescribed by a doctor?

glasses/contacts

When do you need these aids? (For example, walking long distances, walking on rough ground, etc.)

seeing far away

How far can you walk before you have to stop and rest?

100 yards

How long do you rest before you can continue walking?

1/2 hour or more

Do you have problems paying attention?

☒ Yes ☐ No If "Yes", please explain.

I have adult ADHD

Can you finish what you start? (For example, chores, reading, etc.)

☐ Yes ☒ No If "No", please explain.

No, my ADHD makes me not finish.
I also have major anxiety

Can you follow spoken instructions? ☐ Yes ☒ NoCan you follow written instructions? ☒ Yes ☐ No

Have you any problems getting along with bosses, teachers, police, landlords, or other people in authority?

☒ Yes ☐ No If "Yes", please explain.Bosses - Manager - states I am not organized /
Brain fog, can't pay attention

Have you ever lost a job because of problems getting along with people?

☐ Yes ☒ No If "Yes", please explain.

How does stress or changes in schedule affect you?

I cannot concentrate, Rheumatoid arthritis
flares / diarrhea from Crohns, dm pain, Brain fog

Do you have trouble remembering things?

☒ Yes ☐ No If "Yes", please explain.I have short term memory loss
& Brain fog

SECTION D - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the signature block below.

QUESTIONS ABOUT PAIN

When did you first have the pain?

June 2019 it got worse

When did the pain first begin to affect your activities?

June 2019

Are you receiving medical treatment for your pain?

☒ Yes ☐ No If so, please indicate the name, address and telephone number of the doctor or clinic where you are treated.

Dr. Freeman, 1 Guthrie Square, Sayre, PA 18840

Dr. Gellan, Same address

Dr. Georgetown, Same

061912050002129

Have you ever had special tests to evaluate your pain?

[☒] Yes [] No If so, please indicate when and the name and address of where the evaluation was done.

Jabo

What does the pain feel like? Please describe. (For example, is it "dull", "stabbing", an "ache", etc.)

ache, burning, hot

Where do you feel the pain? Please state exactly where the pain is located.

hands, neck, knees, and feet

Does it spread (radiate) to other places?

[☒] Yes [] No If so, please describe where.

to my head, hips, and legs

Since you first experienced the pain, has it changed in how it feels or the part of the body where you feel it? Please describe.

yes, it's gotten worse -
do in my head/neck, knees now, wrists
and hands

How often do you get the pain? all the time

What activities bring on pain? everything I do

How long does it last? all the time

Are you taking any medication for the pain?

[☒] Yes [] No If so, please answer the following:

What is the medication called?

Sulfasalazine
Methotrexate

Sklera

Venaflexine

Alprazolam .25 mg

Amitryptaline 25 mg 1x

Bupropion Folic acid

What is the dosage and how often do you take it?

500mg Sulfasalazine 3 tabs. 2x day
 50mg Methotrexate - 1x every 7 days
 Sklera - Inj every 8 wks
 Venaflexine 150 mg - 1 day
 75 mg - 1 day
 Amitryptaline 25 mg 1x
 Bupropion 300mg 1 day
 Alprazolam .25 1x day
 never relieves pain

When did you first start taking it?

All different dates -
Diagnosed in 2008 - getting worse

Does it have any side effects?

☒ Yes ☐ No If so, what are they?

Fatigue diarrhea anxiety headaches
Dyspepsia stomach aches

In the past, have you taken other pain medication for the pain?

☒ Yes ☐ No If so, why did you stop or change?

Humira - gave me drug induced Lupus
Remicade - allergic reaction

What other things do you do or use to relieve the pain? For example, do you wear or use any devices (such as a cane or a corset) to relieve the pain or treatment? If so, please describe.

Use heating pad, lay down, rest a lot

What are your current daily activities? Weekly activities? (Please describe things like walking, shopping, household chores, driving, socializing, etc.)

resting - I sleep a lot - shop online -
do very little

Has the pain affected your daily activities? If so, please describe what activities and how they have been affected:

Yes, I used to work - I cannot now. I am too exhausted. I cannot sit for long periods, stand, type like I used to -
Who else can tell us about your pain and how it affects your activities?

Jonathan Foote

to -
always in
Bathroom

Anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under federal law.

SIGNATURE

DATE

Jennifer L. Brown

11/20/19

001912050002129



E58

JENNIFER L. BROWN
14 MAIN ST LOT 429
WELLSBURG, NY 14894

IMPORTANT

**YOU MUST RETURN THIS SHEET WITH
ANY INFORMATION YOU SEND TO US.**

**PLEASE NOTE: IF THE ATTACHED LETTER
INCLUDES PAPERWORK THAT NEEDS TO
BE COMPLETED AND RETURNED, YOU
MUST USE THIS SHEET AS A COVER
SHEET. FAILURE TO DO SO, MAY RESULT
IN SIGNIFICANT DELAYS IN PROCESSING
YOUR CLAIM FOR DISABILITY BENEFITS.**

**A SELF ADDRESSED RETURN ENVELOPE HAS
BEEN INCLUDED FOR YOUR CONVENIENCE.**

(3367) ID/Prior Filings**Identifying Information**

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Jennifer Lyn BrownHis or Her Social Security Number(s): **132-58-2507**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**Date of Birth: **10/26/1976**2. Claimant's Alleged Onset Date: **06/19/2019**

3. Potential Onset Date:	06/19/2019, DIB
4. Reason for Potential Onset Date:	
SSI Application Date:	No
Date Last Insured:	No
Date First Insured:	No
Controlling Date:	No
Work Before/After AOD:	No
UWA:	No
SGA:	No
Not SGA:	No
823 In File:	No
Other (Explain Below):	Yes
5. Explanation for Potential Onset Date, when applicable:	From prior claim level

Miscellaneous Information

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case): **12/31/2023**

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If "Yes" and you are not sending the prior folder, enter the following:

(3367) Observations

9. Observations/Perceptions:

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **N. Diles**

Phone Number: **866-964-1715**

Name of Person Completing Form:

Date:

Form SSA-3367 EDCS

DISABILITY REPORT - APPEAL - Form SSA-3441 PAGE: 1 OF 10**(3441) Section 1 - Information About the Disabled Person**

1.A. Name (First, Middle Initial, Last, Suffix): **Jennifer Lyn Brown**

1.B. Social Security Number: **132-58-2507**

1.C. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada:
607-215-0584

Check this box if you do not have a phone or number where we can leave a message

1.D. Alternate Phone Number - another number where we may reach you, if any: **607-483-1886**

1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last) **Jonathan Foote**

2.B. Relationship to Disabled Person **Friend/Neighbor**

2.C. Mailing Address (Street or PO Box)
Include apartment number or unit if applicable. **14 Main Street**
City, State/Province, ZIP/Postal Code, **Lot 429**
Country (if not U.S.) **Wellsburg, PA 14894**

2.D. Daytime Phone Number, including area code
(include IDD and country codes if outside the U.S. or Canada) **607-215-0584**

2.E. Can this person speak and understand English? **Yes**

If no, what language does the contact person prefer?

2.F. Who is completing this form? **Someone else (Please complete the information below).**

2.G. Name (First, Middle, Last) **Jonathan Paul Foster Jr**
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2.H. Relationship to Disabled Person **Appointed Representative (Attorney/Staff)** **EXHIBIT NO. B11E**
PAGE: 2 OF 10
2.I. Mailing Address (Street or PO Box)
Include apartment number or unit if applicable. **303 South Keystone Ave**
City, State/Province, ZIP/Postal Code, **Sayre, PA 18840**
Country (if not U.S.)
2.J. Daytime Phone Number, including area code
(include IDD and country codes if outside **570-888-1529**
the U.S. or Canada)

(3441) Section 3 - Medical Conditions

Date of Last disability report: **10/24/2019**

3.A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your physical or mental conditions?

Yes

Approximate date change occurred:

October 2, 2019

If "Yes", please describe in detail:

worse pain, unable to function some days, has hard time getting up/down, hands hot, inflamed, and medications added.

3.B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions? **Yes**

Approximate date of new conditions:

07/17/2019

If "Yes", please describe in detail:

Enteropathic Arthritis besides Rheumatoid Arthritis

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname.

Yes

If yes, please list the other names used here: **Jennifer Lyn Evans**

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

Physical

If you answered "Yes" to 4.B., please tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

4.D. Name of Facility or Office		Guthrie Clinic					
Name of health care professional who treated you		James Freeman DR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2482 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	October 2, 2019	Date		Date in		Date out	
Last Visit	December 11, 2019	Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Rheumatoid arthritis and Enteropathic arthritis							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
No							
KIND OF TEST				DATES OF TESTS			

4.D. Name of Facility or Office							
Name of health care professional who treated you		MICHAEL J GEORGETSON					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852 - Voice		Patient ID# (if known)			
Mailing Address		GUTHRIE SQ DEPT OF MEDICINE GASTROENTEROLOGY 3RD LEVEL SAYRE, PA 18840-0000					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	07/08/2016	Date		Date in		Date out	
Last Visit	08/2019	Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Crohn's Disease							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
Yes							
KIND OF TEST				DATES OF TESTS			
Blood Test (Not HIV)				08/26/2019			
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

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4.D. Name of Facility or Office		Guthrie Clinic		EXHIBIT NO. B11E			
Name of health care professional who treated you		Michael Gillan DR		PAGE: 5 OF 10			
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2239 - Voice		Patient ID# (if known)			
Mailing Address		One Guthrie Square Sayre, PA 18840					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	08/22/2019	Date		Date in		Date out	
Last Visit	11/15/2019	Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	
What medical conditions were treated or evaluated?							
Hypertension, depression, impingement syndrome, left elbow pain							
What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)							
x-rays, physical therapy, and medications							
Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.							
Yes							
KIND OF TEST					DATES OF TESTS		
X-ray (elbow/shoulder)					08/22/2019		
If you need to list more tests, use SECTION 10 - REMARKS on the last page.							

4.D. Name of Facility or Office							
Name of health care professional who treated you		THOMAS J MCDONALD JR					
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.							
Phone Number		570-887-2852 - Voice		Patient ID# (if known)			
Mailing Address		GUTHRIE SQ DEPT OF MEDICINE GASTROENTEROLOGY 3RD LEVEL SAYRE, PA 18840-0000					
Dates of Treatment (approximate date, if exact date is unknown)							
Office, Clinic or Outpatient visits at this facility		Emergency Room visits at this facility		Overnight hospital stays at this facility			
First Visit	06/11/2018	Date		Date in		Date out	
Last Visit		Date		Date in		Date out	
Next scheduled appointment (if any)		Date		Date in		Date out	

What medical conditions were treated or evaluated?

Crohn's disease

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

medications

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.

No

KIND OF TEST

DATES OF TESTS

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

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EXHIBIT NO. B11E

PAGE: 6 OF 10

4.D. Name of Facility or Office

Guthrie Clinic

Name of health care professional who treated you

Preetika Sinh DR

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number

570-887-2852 - Voice

Patient ID# (if known)

Mailing Address

One Guthrie Square

Sayre, PA 18840

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility

Emergency Room visits at this facility

Overnight hospital stays at this facility

First Visit

Date

Date in

Date out

Last Visit

06/02/2017

Date

Date in

Date out

Next scheduled appointment (if any)

Date

Date in

Date out

What medical conditions were treated or evaluated?

Crohn's disease

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

medications

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future.

No

KIND OF TEST

DATES OF TESTS

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

5. Since you last told us about your other medical information, does anyone else have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

No (Go to SECTION 6 - MEDICINES)

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

(3441) Section 6 - Medicines

6. Are you currently taking any medicines (prescription or non-prescription)? Yes

Yes (Please complete the information below. You may need to look at your medicine containers.)

Name of Medicine	If Prescribed, Give Name of Doctor	Reason for Medicine	Side Effects You Have
Alprazolam	Michael Gillan DR, Guthrie Clinic	Anxiety	drowsiness, constipation, and diarrhea
Amitriptyline	James Freeman DR, Guthrie Clinic	Rheumatoid arthritis	fatigue
Bupropion	Michael Gillan DR, Guthrie Clinic	Depression	Insomnia and drowsiness
Calcium	THOMAS J MCDONALD JR	Crohn's disease	none
Cyanocobalamin	MICHAEL J GEORGETSON	Crohn's disease	none
Cyclobenzaprine	Michael Gillan DR, Guthrie Clinic	Rheumatoid arthritis	none
Folic Acid	MICHAEL J GEORGETSON	Crohn's disease	none
Lisinopril	Michael Gillan DR, Guthrie Clinic	Blood pressure	dizziness and fatigue
Methotrexate	James Freeman DR, Guthrie Clinic	Rheumatoid arthritis	headaches and drowsiness
Ondansetron	Preetika Sinh DR, Guthrie Clinic	Crohn's disease	none
Pantaprazole	Michael Gillan DR, Guthrie Clinic	GERD	none
Sulfasalazine	James Freeman DR, Guthrie Clinic	Rheumatoid arthritis	fatigue and drowsiness
Uslekinumab	MICHAEL J GEORGETSON	Crohn's disease	fatigue and confusion
Veraflaxine	Michael Gillan DR, Guthrie Clinic	Depression	tremor, confusion, anxiety, and drowsiness
Vitamin D3	MICHAEL J GEORGETSON	Crohn's disease	none

(3441) Section 7 - Activities

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

Yes

If yes, please describe in detail:

Worse - having problems with more pain, sitting, standing, trying to get up, and anxiety

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed?

If yes, you will be asked to provide additional information.

No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

No

If yes, what type?

Date(s) attended:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 10 - Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THE ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code) 14 MAIN ST LOT 429 WELLSBURG, NY 14894	e-mail Address (optional)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS



SOCIAL SECURITY ADMINISTRATION

Refer To:
Jennifer Lyn Brown

Office of Hearings Operations
5th Floor
300 S State St
Syracuse, NY 13202-9916
Tel: (888)655-6477

May 13, 2020

Jonathan P Foster, Jr Jr
The Foster Law Office
303 S. Keystone Ave
Sayre, PA 18840

Dear Jonathan P Foster, Jr Jr:

The above named claimant has filed a request for a Social Security hearing, and the record shows that you are representing this person.

Proposed exhibits in the above referenced file are now ready for your review. Please log into <http://ssa.gov/ar/> to view the proposed exhibits which are shown in the exhibit list tab. Further processing of this case requires the following actions on your part:

1. It is the claimant's responsibility to provide medical evidence showing that he/she has an impairment(s) and how severe it is during the time he or she alleges disability. In order to expedite processing of this claim, you should submit the following information:
 - a. All medical records (*not duplicates*) from one year prior to the alleged onset date to the present and any other relevant medical, school or other records not already in file. Please refer to your client's electronic folder to avoid submitting duplicate records.
2. Advise us when all relevant evidence is up-to-date and the case is ready to be scheduled.

Please submit all evidence using one of the three electronic methods:

1. Fax using the enclosed barcode to the FECS server number (877)304-5049,
2. ARS (Appointed Representative Services) website or
3. Contract Scanner (**Note: Please do not send original documents directly to the contract scanner as they will not be returned.**)

Syracuse, NY OHO
P. O. Box 9045
London, KY 40742-9045

As soon as you submit the foregoing, we will review your case to determine if we can make a fully favorable decision without holding a hearing. If we cannot make a decision on the record,

Jennifer Lyn Brown

Page 2 of 2

we will schedule your case for hearing. Therefore, it is to your advantage to submit your evidence as soon as possible.

If you have any questions, please contact the number listed above.

Sincerely,

Mary Jane Pelton
Hearing Office Director

cc: Jennifer Lyn Brown
14 Main St. Lot 429
Wellsburg, NY 14894

Fax the evidence to this fax number:



Claimant: Jennifer Lyn Brown
SSN: 132-58-2507

REPORT OF CONTACT (Use ink or typewriter)							ACCOUNT NUMBER AND SYMBOL 132-58-2507	
TO:	File	NE	MAT	SE	GL	WN	NAME OF WAGE EARNER OR SE PERSON Jennifer Lyn Brown	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	MAM	ODO	OIO	DDS				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
PERSON(S) CONTACTED AND ADDRESSES The Foster Law Office							<input type="checkbox"/> WE OR SE PERSON <input type="checkbox"/> OTHER (specify)	

CONTACT MADE: <input type="checkbox"/> PHONE: 570-888-1529 <input type="checkbox"/> OTHER:	DATE OF CONTACT June 16, 2020
--	----------------------------------

SUBJECT
Telephone Hearing

I spoke with the claimant's representative, Jonathan Foster Jr, I informed the representative that due to the March 2020 COVID-19 guidance we are offering the opportunity for a telephone hearing.

The representative stated that both he and their client are in agreement for a telephone hearing and confirmed the following phone numbers that they can be reached at for the hearing:

Yes _____X_____ No _____

Jonathan Foster Jr: 570-888-1529
Claimant: 607-483-1886

The representative was informed that someone from Social Security will be reaching out to them shortly to schedule a phone hearing. I also asked the representative if they would be willing to waive 75 day advance notice of the hearing and they agreed.

Yes _____X_____ No _____

I sent a 75 day waiver to the claimant and representative.

SIGNATURE Martin S Richards			
HEARING OFFICE (Name, Address & Code) Syracuse (X02) 5th Floor 300 S State St Syracuse, NY 13202-9916	CLAIMS <input checked="" type="checkbox"/> CT <input type="checkbox"/> GS <input type="checkbox"/> AA/PA <input type="checkbox"/> HOD <input type="checkbox"/> OTHER		DATE OF REPORT June 16, 2020 PAGE OF

REPORT OF CONTACT (Use ink or typewriter)							ACCOUNT NUMBER AND SYMBOL 132-58-2507
TO:	File	NE	MAT	SE	GL	WN	NAME OF WAGE EARNER OR SE PERSON Jennifer Lyn Brown
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	MAM	ODO	OIO	DDS			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PERSON(S) CONTACTED AND ADDRESSES							<input type="checkbox"/> WE OR SE PERSON <input type="checkbox"/> OTHER (specify)

CONTACT MADE: <input type="checkbox"/> PHONE: <input type="checkbox"/> OTHER:	DATE OF CONTACT June 23, 2020
SUBJECT	

I spoke with the representative on 6/17/2020. The REP/claimant agreed to a telephone hearing on 7/22/2020 at 11:30AM. I have confirmed the following telephone number for the claimant be used on the day of the hearing.

REP 570-888-1529
Claimant 607-215-0584

REP also agreed to waive 75 days' notice.

SIGNATURE Jennifer Furman		
HEARING OFFICE (Name, Address & Code) Syracuse (X02) 5th Floor 300 S State St Syracuse, NY 13202-9916	CLAIMS <input type="checkbox"/> CT <input type="checkbox"/> GS <input type="checkbox"/> AA/PA <input type="checkbox"/> HOD <input type="checkbox"/> OTHER	DATE OF REPORT June 23, 2020 PAGE OF

Form SSA-5002 (8-1981) EF (02-2001)

Zachary T. Fosberg, CRC
 813 Williams St. Suite 212
 Longmeadow, MA 01106-1148
 (413) 437-5105
 zachary.fosberg@crc-s.com

EDUCATION:

Master of Education in Rehabilitation Counseling	Springfield College (2017)
Bachelor of Science in Rehabilitation & Disability Studies	Springfield College (2015)

CERTIFICATIONS:

Certified Rehabilitation Counselor (00297965)
 RI Qualified Rehabilitation Counselor (18-02)

PROFESSIONAL MEMBERSHIPS:

International Association of Rehabilitation Professionals (SSVE & Forensic Sections)

PROFESSIONAL EXPERIENCE:

CRC Services, LLC **Longmeadow, MA** **(2016-Present)**

Vocational Rehabilitation Consultant

Provide vocational guidance and counseling services to injured workers in Massachusetts and Connecticut to facilitate return to work in suitable employment. This consists of conducting a vocational assessment interview, administering, scoring and interpreting vocational testing (achievement, intelligence, aptitude, dexterity, interest and personality), conducting transferable skills analyses (TSA) in conjunction with the Dictionary of Occupational Titles, (D.O.T.) and other governmental publications; vocational planning and coordination with previous employers to facilitate return to work, job seeking skills training, job development, retraining development and coordination and job placement services. Provide monthly progress reports using word processing software to keep all parties apprised of vocational progress. Perform job analyses, labor market surveys and analysis of workforce numbers, to determine the availability of jobs identified in the TSA or job match report and determine the essential functions of the positions which consist of varying degrees of exertional, non-exertional demand, aptitude, GED, and SVP requirements. Create vocational rehabilitation plans to assist the individual with obtaining suitable employment. Perform employment searches based on the individual's transferable skills, medical work capacity, residual functional capacity and other vocational factors, such as age, education and vocational testing results. Conduct Occupational Analyses on long-term disability matters to include published governmental and proprietary software, labor market analyses and job analyses to determine the essential and non-essential tasks, physical and cognitive demands of occupations. Perform vocational assessments of disabled veterans seeking Total Disability under Individual Unemployability benefits through the Department of Veterans Affairs.

Ensure sensitive information remains confidential.

Center for Human Development **Springfield, MA** **(2015-2017)**
Direct Care Relief Staff

Facilitate a variety of treatment groups for individuals with psychiatric disabilities. Manage a caseload of diverse clients and provide daily, weekly, and bi-monthly documentation and reports. Provided vocational guidance and counseling to individuals wishing to re-enter the workforce. Assisted in identifying suitable vocational recommendations, provided job seeking skills training to include proper application completion, resume development, guidance on job search techniques, proper presentation; among others and assistance with job placement.

New England Business Associates **Springfield, MA** **(05/2016-08/2016)**
Vocational Counselor Intern

Provided vocational case management services to individuals with disabilities and assisted in identification of suitable occupational goals. Conducted job seeking skills training that included resume development, instruction on application completion, interviewing techniques and proper presentation. Contacted employers to determine the availability of suitable positions and encouraged clients to apply.

LACHMAN & GORTON
Attorneys At Law

EDWIN LACHMAN (1923-2012)
PETER A. GORTON

1500 East Main Street
P. O. Box 89
Endicott, New York 13761-0089

PHONE: (607) 754-0500
FAX: (607) 748-6978 (General)
FAX: (607) 484-2132 (Real Estate)
Express Mail: 1500 E. Main Street
Endicott, NY 13760

RICHARD F. MIHALKOVIC
DOROLLO NIXON, JR.

e-mail: office@lglaw.org

September 22, 2020

Social Security Administration
Office of Disability Adjudication & Review
Appeals Council
5107 Leesburg Pike Ste 1400
Falls Church, VA 22041-3255
Via Certified Mail

APPEAL, ATTORNEY FEE AGREEMENT
AND 1696 ARE ENCLOSED

Re: Jennifer Brown
SSN: 132-58-2507

Dear Sir/Madam:

We hereby Appeal the unfavorable decision of the Administrative Law Judge dated August 7, 2020, on the basis of all errors of fact and law including but not limited to failure to properly consider whether claimants condition met a listing, failure to properly find all severe conditions and the functional limitations caused by non-severe conditions and failure to consider the impact of all conditions in combination, failure to properly consider medical evidence of record, medical opinions of record and treating source opinions of record; failure to properly evaluate credibility of claimant and witness testimony, failure to properly consider side effects of medication and the impact of non-exertional impairments, vocational testimony did not establish that there were a significant number of jobs in the national economy especially considering a correct hypothetical reflecting all the proper diminishment of functions, failure to call a medical expert, failure to adequately develop the record, and on the basis that the residual functional capacity (RFC) is insufficiently detailed and is unsupported by the evidence and because the claimant is disabled according to the Social Security Law, rules and regulations.

1. We are enclosing attorney fee agreement and form 1696
2. We will need access to the file and an additional forty-five (45) days thereafter.

Sincerely,



Peter Gorton
Enclosure/cia

cc: Jennifer Brown

EXHIBIT NO. B1F
PAGE: 1 OF 25



NYS Office of Temporary and Disability
Assistance, Division of Disability
Determinations
K. RICHARDSON
PO Box 8783
London, KY 40742-9927

TX#6020-72838

1319081900000065

131908190000065



PO Box 35
Pueblo, CO 81002

866-390-7404 (Toll Free)
719-542-2564 (FAX)
www.verisma.com

Date: 8/12/2019

Fax: 866-323-8335

To: K. RICHARDSON
NYS Office of Temporary and Disability Assistance, Division of Disability
Determinations
PO Box 8783
London, KY 40742-9927
Phone: 800-522-5511x3238

Re: Brown, Jennifer
DOB: 10/26/1976
VSI ID: 6020-72838
Case #: F003DAC9E

Records From: Guthrie Clinic-Sayre Clinic
Guthrie Square
Sayre, PA 18840

Pages in this distribution (including this cover sheet): 28

Please call Customer Service at 866-390-7404 if you experience problems with the receipt of this information.

Requestor Satisfaction Survey

Thank you for requesting medical records. To better serve you in the future, please take a brief survey of your experience at: <https://www.surveymonkey.com/r/verismasurvey1>

STATEMENT OF CONFIDENTIALITY

The information contained is intended for the exclusive use of the addressee and contains confidential or privileged information. If you are not the intended recipient, you are hereby notified that any retention, dissemination, or use of this communication is strictly prohibited. If this information was sent in error, please notify us by phone at the number listed above.

****Please send all available medical records including imaging, diagnostic testing, from 06/19/2017 to present. Thank you.****

131908190000065

Patient ID Number:

Date of Last Exam:

Frequency of Treatment:

Date First Seen:

Height:

Weight:

Blood Pressure, Most Recent, Significant Changes Noted:

Treating Diagnoses:

Please indicate current symptoms:

Treatment and Response:

Please include medications prescribed with dosage and frequency, side effects, and any surgical procedures performed:

Please indicate the expected duration and prognosis of the claimant's condition:

If your patient has displayed any behavior suggestive of a significant psychiatric disorder, please describe (with dates):

History and Subsequent Course:

Please include the date(s) diagnosed & earliest symptoms (e.g. chest pain, weight loss, fatigue, etc.), etiology of impairment, initial findings on physical examination, and subsequent course:

Clinical Findings:

Please describe both positive & negative findings such as any loss of motion in degrees (or estimate the %) site & severity of any neurological deficits, any organ enlargement, & other abnormalities noted.

If fatigue is present:

What are the precipitating factors or types of activities that bring on fatigue, & how soon after starting the activity does the fatigue begin?

Once the fatigue begins, how long must the patient rest before he/she can engage in activities again?

Please describe any physical or other objective signs of chronic fatigue. If depression is present, is it primary or secondary to the fatigue?

Laboratory Findings:

Please include the dates & results of all blood studies, x-rays, pulmonary function studies, & special studies. (Please send a copy of the report.) In cardiac cases, please provide copies of any abnormal EKG tracings or a representative tracing when abnormal findings are not present.

Describe any limitations of physical activity as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity; include specific symptoms and resulting limitations.

Based on the medical findings provided in my report, my medical opinion regarding this individual's ability to do work-related physical activities is as follows:

- Lift and Carry
 - ☐ No Limitation ☐ Limited (Please specify both below)
 - ☐ Occasionally (up to 1/3 of a work day): lbs.
 - ☐ Frequently (up to 2/3 of a work day): lbs.
 - Maximum number of pounds that can be lifted and carried is: lbs.
- Stand and/or Walk
 - ☐ No Limitation ☐ Limited (please check extent below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Up to 2 hours per day ☐ Less than 2 hours per day
- Sit
 - ☐ No Limitation ☐ Limited (please check one below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Less than 6 hours per day
- Push and/or Pull (including hand & foot controls)
 - ☐ No Limitation ☐ Limited (please specify below)
 - ☐ Upper extremities (please describe)
- Other (e.g. postural, manipulative, visual, communicative, environmental)
 - ☐ No Limitation ☐ Limited (please describe below)

☐ I cannot provide a medical opinion regarding this individual's ability to do work-related activities.

Are there any other conditions significant to recovery? ☐ No ☐ Yes
 - If yes, please record your comments below. (If necessary, the reverse of this page may be used.)

Please indicate the best days and times for us to call if we need to ask for additional or clarifying information. Day: Time:

Facility _____ Phone _____

Signature _____ Title _____

Name Printed _____ Date _____

131908190000065



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

1/22/2018 11:20 AM	Provider Michael F Gillan	Department Sayre Family Practice	Har	Center SAYRE
--------------------	------------------------------	--	-----	-----------------

Office Visit

1/22/2018

Jennifer Lyn Brown

MRN: 340616

Nursing Note

Prough, Shannon, LPN at 1/22/2018 11:20 AM

Status: Signed

PATIENT: Jennifer Lyn Brown

MRN: 340616

DATE OF SERVICE: 1/22/2018

Chief Complaint

Patient presents with

- Medication Check

Patient here for a medication check. C/O left knee pain

Shannon Prough, LPN 1/22/2018 11:30

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM

Author: Gillan, Michael F, DO

Service: —

Author Type: Physician

Filed: 1/22/2018 4:17 PM

Encounter Date: 1/22/2018

Status: Signed

Editor: Gillan, Michael F, DO (Physician)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)

DATE OF SERVICE: 1/22/2018

CHIEF COMPLAINT:**Chief Complaint**

Patient presents with

- Medication Check

*Patient here for a medication check. C/O left knee pain***Subjective****HISTORY OF PRESENT ILLNESS:**

Jennifer Lyn Brown is a 41-y.o. female.

HPI

1. Here for follow up of anxiety and depression. Doing well on current therapy. Denies any issues or concerns. Verbally contracts for safety. Taking medications without side effects or other concerns.

2. Hypertension. The patient is taking hypertensive medications compliantly without side effects. Denies chest pain, dyspnea, edema, or TIA's.

3. Here with left knee pain. States no injury. Pain only in the back of the knee when sitting or lying down. No swelling or injury. No pain when walking, going up or down stairs, or getting in and out of the care. Occasionally wakes her from sleep but able to go back to sleep. Motrin and tylenol are helpful. No ankle or hip pain she is aware of. No radicular symptoms. No back pain. No loss of bowel or bladder control.

4. History of B12 deficiency. On supplements. No issues or concerns. Due to have the levels checked.

5. Sinus pressure and pain since 1/1/2018. Using over the counter treatments with limited success. States she would like an antibiotic.

Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

The patient denies cough, chest pain, dyspnea, wheezing or hemoptysis.

The patient denies abdominal or flank pain, anorexia, nausea or vomiting, dysphagia, change in bowel habits or black or bloody stools or weight loss.

The patient denies any symptoms of neurological impairment or TIA's; no amaurosis, diplopia, dysphasia, or unilateral disturbance of motor or sensory function. No loss of balance or vertigo.

Past Medical History:**Diagnosis**

- Anal fissure

Date

1/2013

- Anxiety

- Attention deficit

- Back ache

3/18/2014

- Calcaneal spur

6/30/2008

- Cherry angioma

8/9/2016

- Cholecystitis

- CHRONIC SINUSITIS NOS

5/23/2005



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)

CT 2005

- Crohn disease (HCC)
- Depression 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- *Sees Dr. Freeman in Elmira.*
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
<i>Anxiety</i>		
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		
• Heart	Father	
<i>?Marfan's Syndrome</i>		
• Heart	Paternal Uncle	
<i>Aortic Dissection, Marfan's Syndrome</i>		
• Psychiatry	Maternal Aunt	
<i>ADHD</i>		
• Genetic	Maternal Aunt	
<i>Marfan syndrome</i>		
• Psychiatry	Other	
<i>ADHD</i>		

Current Outpatient Prescriptions

Medication

- buPROPion (WELLBUTRIN XL) Sig Take 1 Tab by mouth DAILY.



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)

- 300 MG Oral TABLET SR 24 HR
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1,000 mcg within a muscle EVERY THIRTY DAYS.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap Take 50,000 Units by mouth EVERY 7 DAYS.

No current facility-administered medications for this visit.

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Rash
Rash

Social History**Social History Main Topics**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use: No
- Drug use: No
- Sexual activity: Yes
- Partners: Male
- Birth control/ protection: Pill, Condom
- Comment: OCPs

Other Topics

- Not on file

Concern

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.



Notes Report

1 3 1 9 0 8 1 9 0 0 0 0 6 5

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative for chills, diaphoresis, fever and malaise/fatigue.

HENT: Positive for congestion. Negative for hearing loss and sore throat.

Eyes: Negative for blurred vision, double vision and photophobia.

Respiratory: Negative for cough, sputum production and shortness of breath.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and leg swelling.

Gastrointestinal: Negative for abdominal pain, blood in stool, constipation, diarrhea, melena, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency and urgency.

Musculoskeletal: Positive for joint pain. Negative for back pain, falls, myalgias and neck pain.

Neurological: Negative for dizziness and tingling.

Psychiatric/Behavioral: Negative for depression and suicidal ideas. The patient is not nervous/anxious.

Well controlled.**Objective****PHYSICAL EXAM:**

VITALS: BP 130/90 (BP Location: Left arm, Patient Position: Sitting) | Pulse 93 | Temp 98.4 °F (36.9 °C) (Tympanic) | Resp 18 | Wt 290 lb (131.5 kg) | SpO2 98% Comment: room air | Breastfeeding? No | BMI 40.45 kg/m² Body mass index is 40.45 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

Frontal and maxillary sinus pain to palpation, left worse than right.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness. There is no rebound.

Musculoskeletal:

Left hip: She exhibits normal range of motion, normal strength, no bony tenderness, no swelling, no crepitus, no deformity and no laceration.

Left knee: She exhibits normal range of motion, no effusion, no deformity, normal alignment, no LCL laxity, normal patellar mobility, no bony tenderness, normal meniscus and no MCL laxity. No tenderness found. No medial joint line, no lateral joint line, no MCL, no LCL and no patellar tendon tenderness noted.



Notes Report

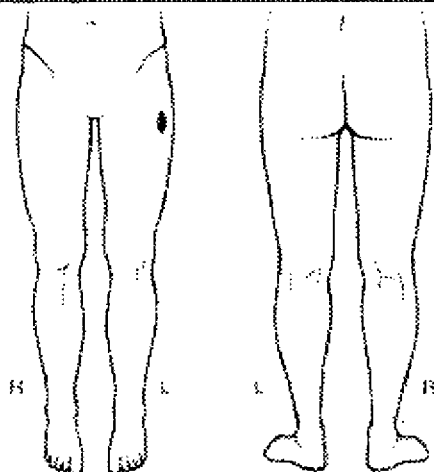
131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)



Legs:

Pain over the trochanteric bursa.

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. Gait normal.

Skin:

No CVA tenderness on exam.

Psychiatric: Mood and affect normal.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. Acute pain of left knee	719.46	M25.562	XR KNEE 4 OR MORE VIEWS (STANDARD)
2. GAD (generalized anxiety disorder)	300.02	F41.1	venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR
			venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR
3. HTN (hypertension), benign	401.1	I10	lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab
			LIPID PROFILE
4. Depression, unspecified depression type	311	F32.9	buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR
5. Trochanteric bursitis of left hip	726.5	M70.62	
6. Vitamin B12 deficiency	266.2	E53.8	
7. Sinus pressure	478.19	J34.89	

Plan

1. Acute pain in the knee for a few weeks: No real improvement with conservative therapy. Will obtain x-ray looking for arthritis. No injury, no swelling, no signs or symptoms of DVT. There is also some mild pain over the trochanteric bursa of the left hip. Discussed injections which patient will consider. In the meantime, advised rest, ice, compression, elevation of the knee. Follow up after testing, sooner as needed.

2. GAD: Chronic and stable, as is the depression. Would like to continue on current therapy. Verbally contracts for safety.

3. Hypertension: Goal 140/90 or less. Well controlled, continue current therapy.



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2018

Progress Notes by Gillan, Michael F, DO at 1/22/2018 11:20 AM (continued)

4. B12 deficiency: Chronic and stable, continue on current therapy and recheck levels.

5. Sinus pressure, worse over the last 20 days. No significant improvement with conservative therapy. Given the duration of symptoms will treat with amoxicillin. Advised to let her provider with her crohns medications know of this. Advised to take probiotic.

Follow up in 3 to 4 months, sooner as needed.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

Labs ordered. Need to be done fasting. Nothing to eat or drink (except water, black tea, or black coffee) after 8pm the night before. Arrive to 2 Orange for bloodwork to be drawn. Monday-Friday 7am-5:30pm, Saturday 7am-12N.

X-ray on two purple.

I will contact you with the results.

Medications refilled.

Call with any questions or concerns.

Thank you!

Michael F Gillan, DO

Author: Michael F Gillan, DO 1/22/2018 16:14

Electronically signed by Gillan, Michael F, DO at 1/22/2018 4:17 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

Generated on 8/7/19 2:13 PM



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/13/2018

Contact Information (continued)

	Provider	Department	Har	Center
3/13/2018 10:00 AM	Megan Nichole Trecartin	Sayre Family Practice		SAYRE

Office Visit

3/13/2018

Jennifer Lyn Brown

MRN: 340616

Nursing Note

Prough, Shannon, LPN at 3/13/2018 10:00 AM

Status: Signed

PATIENT: Jennifer Lyn Brown

MRN: 340616

DATE OF SERVICE: 3/13/2018

Chief Complaint

Patient presents with

- Sinus Problem

Patient here c/o continued sinus congestion and headache

Shannon Prough, LPN 3/13/2018 10:10

Progress Notes by Gillan, Michael F, DO at 3/13/2018 10:00 AM

Author: Gillan, Michael F, DO

Service: —

Author Type: Physician

Filed: 3/13/2018 1:16 PM

Encounter Date: 3/13/2018

Status: Signed

Editor: Gillan, Michael F, DO (Physician)

Guthrie Clinic/RPH Supervising DO Documentation

Date of Service: 3/13/2018

B#: 340616

I discussed the patient with the resident. I agree with the assessment, diagnostic and treatment plan as documented in the resident's note.

- Chronic headaches, no "red flag symptoms."
- Has had CT of her head and sinuses in the past.
- Clarify if using CPAP.
- Follow up if symptoms worsen or fail to resolve.
- ED with severe or life threatening symptoms.

Michael F Gillan, DO

Supervising Physician

Department of Family Medicine



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/13/2018

Progress Notes by Gillan, Michael F, DO at 3/13/2018 10:00 AM (continued)

Electronically signed by Gillan, Michael F, DO at 3/13/2018 1:16 PM

Chart Cosign

Accepted By

Gillan, Michael F, DO

Accepted On

3/13/2018 1:53 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

6/21/2018 11:20 AM	Provider	Department	Har	Center
	Megan Nichole Trecartin	Sayre Family Practice		SAYRE

Office Visit

6/21/2018

Jennifer Lyn Brown

MRN: 340616

Nursing Note

Lantz, Tricia, LPN at 6/21/2018 11:20 AM

Status: Signed

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 6/21/2018

Chief Complaint

Patient presents with

- Bee Sting
Stung Tuesday. Left side of face. Swelling

B12 injection 1,000 mcg given in LD without incident.

Author: Tricia Lantz, LPN 6/21/2018 11:31



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/21/2018

Progress Notes by Gillan, Michael F, DO at 6/21/2018 11:20 AM

Author: Gillan, Michael F, DO

Service: —

Author Type: Physician

Filed: 6/22/2018 7:42 AM

Encounter Date: 6/21/2018

Status: Signed

Editor: Gillan, Michael F, DO (Physician)

Guthrie Clinic/RPH Supervising DO Documentation

Date of Service: 6/21/2018 B#: 340616

I discussed the patient with the resident. I agree with the assessment, diagnostic and treatment plan as documented in the resident's note.

Michael F Gillan, DO
Supervising Physician
Department of Family Medicine

Electronically signed by Gillan, Michael F, DO at 6/22/2018 7:42 AM

Chart Cosign

Accepted By:
Gillan, Michael F, DO

Accepted On:
6/22/2018 7:42 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

11/21/2018 10:00 AM	Provider	Department	Har	Center
	Matthew Lim Braslow	Sayre Family Practice		SAYRE

Office Visit
11/21/2018

Jennifer Lyn Brown
MRN: 340616

Nursing Note**Woodruff, Shannon, LPN at 11/21/2018 10:00 AM**

Status: Signed

PATIENT: Jennifer Lyn Brown
MRN: 340616

Generated on 8/7/19 2:13 PM



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 11/21/2018

Nursing Note (continued)**Woodruff, Shannon, LPN at 11/21/2018 10:00 AM (continued)**

DOB: 10/26/1976

DATE OF SERVICE: 11/21/2018

Chief Complaint

Patient presents with

- URI
started sunday x 3 days. cough, sore throat, post nasal drip, bilat ears full, non productive cough.
- Sinus Problem
taking mucinex etc. has been off all week.

Author: Shannon Woodruff, LPN 11/21/2018 10:10

Progress Notes by Gillan, Michael F, DO at 11/21/2018 10:00 AM

Author: Gillan, Michael F, DO

Service: —

Author Type: Physician

Filed: 11/23/2018 11:20 PM

Encounter Date: 11/21/2018

Status: Signed

Editor: Gillan, Michael F, DO (Physician)

Guthrie Clinic/RPH Supervising DO Documentation

Date of Service: 11/21/2018 B#: 340616

I discussed the patient with the resident. I agree with the assessment, diagnostic and treatment plan as documented in the resident's note.

Michael F Gillan, DO
Supervising Physician
Department of Family Medicine

Electronically signed by Gillan, Michael F, DO at 11/23/2018 11:20 PM

Chart Cosign

Accepted By

Gillan, Michael F, DO

Accepted On

11/24/2018 1:50 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT	607-215-0584 (H)	jenlyn9598@yahoo.c	GUTHRIE MEDICAL	



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Patient Demographics (continued)

429 WELLSBURG NY 14894	607-483-1886 (M)	om	GROUP EMPLOYEES
Reg Status Verified	PCP Gillan, Michael F, DO570-887-2239		

Contact Information

1/31/2019 1:40 PM	Provider Michael F Gillan	Department Sayre Family Practice	Har	Center SAYRE
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Office Visit

1/31/2019

Jennifer Lyn Brown

MRN: 340616

Nursing Note

Prough, Shannon, LPN at 1/31/2019 1:40 PM

Status: Signed

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 1/31/2019

Check Up (Patient here requestion genetic testing. C/O brain fog, difficulty focusing, and memory issues.)

Author: Shannon Prough, LPN 1/31/2019 14:11

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM

Author: Gillan, Michael F, DO	Service: —	Author Type: Physician
Filed: 2/5/2019 10:17 AM	Encounter Date: 1/31/2019	Status: Signed
Editor: Gillan, Michael F, DO (Physician)		

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 1/31/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Check Up

Patient here requestion genetic testing. C/O brain fog, difficulty focusing, and memory issues.



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

Subjective**HISTORY OF PRESENT ILLNESS:**

Jennifer Lyn Brown is a 42-y.o. female.

HPI

1. Patient is here with the following concerns:

- Fatigued, brain fog, not sleeping well.
- Have trouble concentrating.
- States her symptoms started after the passing of her father. States that she notices they seem stable. States she feels like she is going through the normal grieving process. Notes she is concerned that she may have ADHD or recurrence of her sleep apnea. She was diagnosed with sleep apnea in 2013. Her CPAP titration note from 6/28/2018 states "Good response to CPAP. Consider CPAP at 14 cm of water pressure with heated humidifier, weight reduction program and good sleep hygiene."
- She notes she feels very similar to when she had undiagnosed sleep apnea.
- She had gastric bypass (laparoscopic sleeve gastrectomy on 12/10/2014).
- Her preoperative weight was 334 pounds, currently 289 pounds.
- She states she was told prior she didn't need the CPAP after surgery, thus has not been using it.
- She also requests genetic testing for Marfan syndrome, as her father passed away from this.

Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

The patient denies cough, chest pain, dyspnea, wheezing or hemoptysis.

The patient denies abdominal or flank pain, anorexia, nausea or vomiting, dysphagia, change in bowel habits or black or bloody stools or weight loss.

The patient denies any symptoms of neurological impairment or TIA's; no amaurosis, diplopia, dysphasia, or unilateral disturbance of motor or sensory function. No loss of balance or vertigo.

Sleep History and Assessment:

Excessive Daytime sleepiness, Non restorative sleep, loud snoring.

Symptoms for more than 30 days.

ICD 10 Code: G47.33 with known severe sleep apnea.

Mallampati score of 4.

Epworth Sleepiness scale: 6 points.

MMSE: 29/30.

Does states she has history of ADHD as a child as well.

Past Medical History:

Diagnosis

• Anal fissure

• Anxiety

• Attention deficit

• Back ache

• Calcaneal spur

• Cherry angioma

• Cholecystitis

• CHRONIC SINUSITIS NOS

CT 2005

Date

1/2013

3/18/2014

6/30/2008

8/9/2016

5/23/2005



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

- Crohn disease (HCC)
- Depression 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

- | | |
|------------------------------|----------------------|
| • Psychiatry
ADHD | Maternal Aunt |
| • Genetic
Marfan syndrome | Maternal Aunt |
| • Psychiatry
ADHD | Other |
| • Cancer | Paternal Grandfather |
| • Glaucoma | No family history |
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Medications

- | Medication | Sig |
|--|--|
| • buPROPion (WELLBUTRIN XL)
300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE)
600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3)
1000 units Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyanocobalamin (VITAMIN B12)
1000 MCG/ML Injection Solution | Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. |
| • cyclobenzaprine (FLEXERIL) 10
MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS
NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML
Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • ergocalciferol (DRISDOL,
CALCIFEROL, VITAMIN D) 50000
units Oral Cap | Take 1 Cap by mouth EVERY 7 DAYS. Take times 8
weeks. |
| • ergocalciferol (DRISDOL,
CALCIFEROL, VITAMIN D) 50000
units Oral Cap | Take 1 Cap by mouth EVERY 7 DAYS for 4 doses. |
| • fluticasone (FLONASE) 50
MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. |
| • foliC acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • Insulin Syringe-Needle U-100 31G
X 3/8" 0.5 ML Does not apply Misc | 25 mg by Does not apply route EVERY 7 DAYS. Use
weekly for methotrexate |
| • Insulin Syringe-Needle U-100 31G
X 3/8" 0.5 ML Does not apply Misc | Inject 1 mL beneath the skin EVERY 7 DAYS. Use with
methotrexate weekly |
| • levonorgestrel-ethinyl estradiol
triphasic (LEVONEST) Oral Tab | Take 1 Tab by mouth DAILY. |
| • lisinopril (PRINIVIL, ZESTRIL) 20
MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • loratadine (CLARITIN, ALAVERT)
10 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • methotrexate sodium, PF, (MTX)
50 MG/2ML Injection Solution | Inject 1 mL beneath the skin EVERY SATURDAY. |
| • Nitroglycerin 0.4 % Rectal
Ointment | Place 1 Appl per rectum TWICE DAILY. Apply with cotton
applicator. |
| • ondansetron (ZOFTRAN ODT) 8
MG Oral TABLET DISPERSIBLE | Take 1 Tab by mouth EVERY EIGHT HOURS AS
NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG
Oral Tab EC | Take 1 Tab by mouth DAILY. |



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

- predniSONE (DELTASONE) 10 MG Oral Tab Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking differently: 20 mg. Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days)
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS.
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications**Medication**

- saline (OCEAN) nasal spray 0.65 %

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling

Rash

Rash

Social History**Socioeconomic History**

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity - worry: Not on file
- Food insecurity - inability: Not on file
- Transportation needs - medical: Not on file
- Transportation needs - non-medical: Not on file

Occupational History

- Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 oz
- Drug use: No
- Sexual activity: Yes
- Partners: Male
- Birth control/protection: Pill, Condom



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)*Comment: OCPs*

Other Topics

Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Over the last 2 weeks, have you been feeling down, depressed, anxious, or hopeless?: 1

Over the past 2 weeks, have you felt little interest or pleasure in doing things?: 3

Trouble falling or staying asleep, or sleeping too much?: 3

Feeling tired or having little energy?: 3

Poor appetite or overeating?: 3

Feeling bad about yourself or that you are a failure or have let yourself or your family down?: 0

Trouble concentrating on things, such as reading the newspaper or watching TV?: 3

Moving or speaking so slowly that other people notice OR being fidgety and restless?: 2

Thoughts that you would be better off dead or of hurting yourself in some way?: 0

PHQ-9 TOTAL SCORE: 18

How difficult have these problems made it for you to do your work, take care of things at home or get along with people?: Extremely difficult

In the past 2 years, have you felt depressed or sad most days, even if you felt ok?: No

REVIEW OF SYSTEMS:

ROS

A comprehensive review of systems was conducted with the patient and is negative unless noted above.

Objective**PHYSICAL EXAM:**VITALS: BP 122/72 (BP Location: Left arm, Patient Position: Sitting) | Pulse 92 | Temp 98.8 °F (37.1 °C) (Tympanic) | Resp 18 | Wt 289 lb (131.1 kg) | LMP 01/03/2019 (Approximate) | SpO2 97% Comment: room air | Breastfeeding? No | BMI 40.31 kg/m² Body mass index is 40.31 kg/m².Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

TM's clear bilaterally

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

Lymphadenopathy:

Generated on 8/7/19 2:13 PM



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She displays normal reflexes. No cranial nerve deficit or sensory deficit. She exhibits normal muscle tone. Coordination normal.

Skin: Skin is warm and dry. No rash noted. No erythema. No pallor.

Psychiatric: Her speech is normal and behavior is normal. Judgment and thought content normal. Her mood appears not anxious. Her affect is not angry, not blunt, not labile and not inappropriate. She is not actively hallucinating. Cognition and memory are normal. She does not exhibit a depressed mood.

Still grieving the loss of her father. She is attentive.

Mallampati score of 4.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. OSA (obstructive sleep apnea)	327.23	G47.33	REFER TO SLEEP STUDY LAB
2. Attention deficit hyperactivity disorder (ADHD), unspecified ADHD type	314.01	F90.9	REFER TO PSYCHOLOGY
3. Grief reaction	309.0	F43.21	REFER TO PSYCHOLOGY
4. Family history of Marfan syndrome	V19.5	Z82.79	REFER TO GENETICS

Plan**1. OSA:**

- Severe on last titration study.
- States she was told by bariatrics she did not need this any longer.
- I believe she still has untreated sleep apnea, especially given her weight, symptoms, and prior diagnosis.
- I feel sleep study should be in the hospital given the high likelihood of sleep apnea and false negative rate of home sleep study.
- Patient agreeable, testing ordered.

2. Prior History of ADHD:

- Referred to Psychology for evaluation.

3. Grief reaction:

- Elevated PHQ 9 with no thoughts of hurting self or others.
- Symptoms started after death of her father.
- Referred to Psychology.
- Will try melatonin for sleep at night.

4. Family history of Marfan Syndrome:

- Reviewed prior cardiac testing.
- Referred to Genetics for testing.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

See Dr. Goldberg.



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

Obtain the Sleep Study.

Follow up in 1 month, sooner as needed.

Call with any questions or concerns.

Melatonin (By mouth)**Melatonin (mel-a-TOE-nin)****Treats insomnia.****Brand Name(s):**Good Neighbor Pharmacy Melatonin, Nature's Blend Melatonin, PharmAssure Melatonin, Rite Aid Melatonin, Sundown Naturals Melatonin

There may be other brand names for this medicine.

When This Medicine Should Not Be Used:

You should not use this medicine if you have had an allergic reaction to melatonin.

How to Use This Medicine:**Capsule, Long Acting Capsule, Liquid, Tablet, Long Acting Tablet**

- Your doctor will tell you how much medicine to use. Do not use more than directed.
- Follow the instructions on the medicine label if you are using this medicine without a prescription.
- Take your dose 20 minutes before your bedtime. You may take this medicine with or without food.
- The liquid may be taken directly or combined with water or juice.

If a dose is missed:

- If you miss a dose or forget to use your medicine, call your doctor or pharmacist for instructions.

How to Store and Dispose of This Medicine:

- Store the medicine in a closed container at room temperature, away from heat, moisture, and direct light.
- Keep all medicine out of the reach of children. Never share your medicine with anyone.
- Ask your pharmacist, doctor, or health caregiver about the best way to dispose of any outdated medicine or medicine no longer needed.

Drugs and Foods to Avoid:**Ask your doctor or pharmacist before using any other medicine, including over-the-counter medicines, vitamins, and herbal products.**

- Make sure your doctor knows if you are also using any tranquilizer medicines, or if you are also using any sedative medicines.

Warnings While Using This Medicine:

- Make sure your doctor knows if you are pregnant or breast feeding, or if you have an autoimmune condition. Make sure your doctor knows if you are feeling sad or depressed.
- This medicine may make you drowsy. Avoid driving, using machines, or doing anything else that might be dangerous if you are not alert.

Possible Side Effects While Using This Medicine:**If you notice these less serious side effects, talk with your doctor:**

- Feeling sluggish or tired in the morning.
- Headache.

If you notice other side effects that you think are caused by this medicine, tell your doctor.**Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088**

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The above information is an educational aid only. It is not intended as medical advice for individual conditions or treatments. Talk to your doctor, nurse or pharmacist before following any medical regimen to see if it is safe and effective for you.



Notes Report

131908190000065

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Progress Notes by Gillan, Michael F, DO at 1/31/2019 1:40 PM (continued)

Author: Michael F Gillan, DO 2/5/2019 09:50

Electronically signed by Gillan, Michael F, DO at 2/5/2019 10:17 AM

END OF REPORT

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

**Summarization of Episode Note
Continuity of Care Document****Received From: Guthrie Health System**

MEGAHIT sent a request for electronic medical records from the following claimant-provided source(s):

Source Type:	Doctor/Therapist
Source Name:	Guthrie Clinic
Address:	1 GUTHRIE SQUARE SAYRE, PA 18840
Voice Phone:	570-887-2852
Source Type:	Hospital/Clinic
Source Name:	ROBERT PACKER HOSPITAL
Address:	MEDICAL RECORDS 1 GUTHRIE SQ SAYRE, PA 18840
Voice Phone:	570-887-4336
Source Type:	Doctor/Therapist
Source Name:	Guthrie Clinic
Address:	1 Guthrie Square SAYRE, PA 18840
Voice Phone:	570-887-2852
Source Type:	Doctor/Therapist
Source Name:	Guthrie Clinic
Address:	1 GUTHRIE SQUARE SAYRE, PA 18840
Voice Phone:	570-888-5858
Source Type:	Doctor/Therapist
Source Name:	Guthrie Clinic
Address:	1 Guthrie Square Sayre, PA 18840
Voice Phone:	570-887-2239

Creation Date:
06/27/2019

Date Range Requested:
06/19/2018 - 06/27/2019

Type of Request:
MEGAHIT Triggered

Jennifer Lyn Brown
SSN: 132-58-2507

DOB: 10/26/1976

Sex: Female

Partner Medical Record Demographics:

Name: Jennifer Lyn Brown **DOB:** 10/26/1976

Sex: Female

Table of Contents

- Problems List [PROB LIST]
- Encounters [ENC]
- Procedures [PROCED]
- Laboratory Results [LABS]
- Vital Signs [VITALS]
- Medication Information [MEDS]
- Plan of Care [CARE PLAN]
- Healthcare Providers [PROV LIST]

PROB LIST

Problems List

<u>Problem [Code]</u>	<u>Occurrences</u>	<u>First Date</u>	<u>Last Date</u>	<u>Associated Types</u>	<u>Last Prognosis Value</u>	<u>Last Prognosis Date</u>
Fibromyalgia [M79.7] Myalgia and myositis NOS [729.1] Fibromyalgia [44098]	1	08/20/2014	-	Disease		
Impingement syndrome of left shoulder [M75.42] Shoulder region dis NEC [726.2] Impingement syndrome of left shoulder [1584121]	1	03/01/2019	-	Disease		
Other long term (current) drug therapy [Z79.899] Long-term use meds NEC [V58.69] Long term current use of immunosuppressive drug [63735183]	1	12/27/2016	-	Disease		
Arthralgia of the upper arm [267950000] Pain in unspecified elbow [M25.529] Joint pain-up/arm [719.42] Pain in joint, upper arm [82717]	1	10/30/2018	-	Disease		
Attention deficit hyperactivity disorder [406506008] Attention-deficit hyperactivity disorder, unspecified type [F90.9] Attn deficit w hyperact [314.01] ADHD (attention deficit hyperactivity disorder) [193722]	1	12/28/2012	-	Disease		
Benign hypertension [10725009] Essential (primary) hypertension [I10] Benign hypertension [401.1] HTN (hypertension), benign [514387]	1	10/07/2008	-	Disease		
Chronic sinusitis [40055000] Chronic sinusitis, unspecified [J32.9]	1	05/23/2005	-	Disease		

Chronic sinusitis NOS [473.9] Unspecified sinusitis (chronic) [56546]					
Cobalamin deficiency [190634004] Deficiency of other specified B group vitamins [E53.8] B-complex defic NEC [266.2] Vitamin B12 deficiency [56922]	1	02/09/2017	-	Disease	
Crohn's disease [34000006] Crohn's disease, unspecified, without complications [K50.90] Regional enteritis NOS [555.9] Crohn's disease [41297]	1	07/08/2016	-	Disease	
Depressive disorder [35489007] Major depressive disorder, single episode, unspecified [F32.9] Depressive disorder NEC [311] Depression [41696]	1	01/20/2014	-	Disease	
Dry eyes [162290004] Dry eye syndrome of bilateral lacrimal glands [H04.123] Tear film insuffic NOS [375.15] Bilateral dry eyes [1723793]	1	06/27/2017	-	Disease	
Environmental allergy [426232007] Other allergy status, other than to drugs and biological substances [Z91.09] Hx-allergy NEC [V15.09] Environmental allergies [602827]	1	01/05/2014	-	Disease	
Eruption due to drug [28926001] Generalized skin eruption due to drugs and medicaments taken internally [L27.0] Drug dermatitis NOS [693.0] Drug eruption [41806]	1	11/23/2016	-	Disease	
Eruption [271807003] Rash and other	1	12/05/2016	-	Disease	

skin NOS [216.9] Multiple benign nevi [5724378]					
Myopia [57190000] Myopia, bilateral [H52.13] Myopia [367.1] Myopia of both eyes [1619756]	1	06/27/2017	-	Disease	
Neuritis [84299009] Neuralgia and neuritis, unspecified [M79.2] Neuralgia/neuritis NOS [729.2] Neuritis [50625]	1	08/09/2016	-	Disease	
Non-toxic multinodular goiter [36241006] Nontoxic multinodular goiter [E04.2] Nontox multinodul goiter [241.1] Nontoxic multinodular goiter [45270]	1	01/18/2011	-	Disease	
Obesity [414916001] Obesity, unspecified [E66.9] Obesity NOS [278.00] Obesity [92278]	1	10/22/2010	-	Disease	
Obstructive sleep apnea syndrome [78275009] Obstructive sleep apnea (adult) (pediatric) [G47.33] Obstructive sleep apnea [327.23] Severe obstructive sleep apnea [25715530]	1	06/10/2013	-	Disease	
Patient encounter status [305058001] Encounter for therapeutic drug level monitoring [Z51.81] Therapeutic drug monitor [V58.83] Therapeutic drug monitoring [818990]	1	05/02/2017	-	Disease	
Plantar fascial fibromatosis [13370002] Plantar fascial fibromatosis [M72.2] Plantar fibromatosis [728.71] Plantar fascial fibromatosis [1981]	1	09/09/2004	-	Disease	

Primary focal hyperhidrosis [427794001]	1	05/24/2010	-	Disease
Generalizd hyperhidrosis [780.8]				
Rheumatoid arthritis [69896004]	1	12/12/2008	-	Disease
Rheumatoid arthritis, unspecified [M06.9]				
Rheumatoid arthritis [714.0]				
Rheumatoid arthritis [1401]				
Senile angioma [5050001]	1	08/09/2016	-	Disease
Hemangioma of skin and subcutaneous tissue [D18.01]				
Hemangioma skin [228.01]				
Cherry angioma [960835]				
Solar degeneration [43982006]	1	08/09/2016	-	Disease
Other skin changes due to chronic exposure to nonionizing radiation [L57.8]				
Oth dermatitis solar rad [692.79]				
Sun-damaged skin [800593]				
Vitamin D deficiency [34713006]	1	02/09/2017	-	Disease
Vitamin D deficiency, unspecified [E55.9]				
Vitamin D deficiency NOS [268.9]				
Vitamin D deficiency [88575]				

Narrative Text

Problem	Noted Date
Eyelid twitch	04/22/2019
Impingement syndrome of left shoulder	03/01/2019
Overview:	
Added automatically from request for surgery 425306	
Pain in joint, upper arm	10/30/2018
Myopia of both eyes	06/27/2017
Bilateral dry eyes	06/27/2017
Therapeutic drug monitoring	05/02/2017
Vitamin D deficiency	02/09/2017
Vitamin B12 deficiency	02/09/2017
Long term current use of immunosuppressiv e drug	12/27/2016
Rash	12/05/2016
Drug eruption	11/23/2016

likely, Remicade vs Wellbutrin	
Multiple benign nevi	08/09/2016
Cherry angioma	08/09/2016
Sun-damaged skin	08/09/2016
Neuritis	08/09/2016
Overview:	
on palms	
Crohn's disease	07/08/2016
Tremor of left hand	03/15/2016
Benign head tremor	03/15/2016
Status post bariatric surgery	12/26/2014
Fibromyalgia	08/20/2014
Depression	01/20/2014
Environmental allergies	01/05/2014
Severe obstructive sleep apnea	06/10/2013
ADHD (attention deficit hyperactivity disorder)	12/28/2012
Nontoxic multinodular goiter	01/18/2011
Obesity	10/22/2010
Overview:	
Body mass index is 38.53 kg/(m^2).	
GAD (generalized anxiety disorder)	10/22/2010
Overview:	
On Paxil 40mg daily	
Hyperhidrosis disorder	05/24/2010
Rheumatoid arthritis	12/12/2008
Overview:	
Sees Dr. Freeman in Elmira.	
HTN (hypertension), benign	10/07/2008
GERD (Gastroesophagea I Reflux Disease)	10/07/2008
Unspecified sinusitis (chronic)	05/23/2005
Overview:	
CT 2005	
Plantar fascial fibromatosis	09/09/2004

ENC

Encounters

Date	Type	Specialty	Care Team	Description
06/26/2019	Hospital Encounter			Robert Packer Hospital 06/26/2019
06/26/2019	Gastro Nurse/clinical support			Outpatient Crohn's disease of small intestine with other complication (IHC) (Pimary Dx)

Nursing Note - Williams, Kimberly, RN - 06/26/2019 3:30 PM EDT

Patient arrives with significant other for every 8 week injection of Stelara. Patient identified by verbalizing name and date of birth. Stelara 90 mg given SQ to right upper arm. Tolerates well with NAR. Band-aid applied. Escorted to desk to schedule 8 week nurse teach visit. Significant other would like to learn to give injections at home.

Electronically signed by Williams, Kimberly, RN at 06/26/2019 4:20 PM EDT
06/26/2019 Telephone Williams, Kimberly, RN Orders (lab And Procedure)

SAYRE

06/26/2019

Telephone Encounter - Williams, Kimberly, RN - 06/26/2019 4:06 PM EDT

Orders pended for yearly quantiferon TB gold. Hx Crohn's on Stelara. Last done 3/18. Please sign. Thanks.

Electronically signed by Williams, Kimberly, RN at 06/26/2019 4:09 PM EDT
06/21/2019 Hospital Encounter

Robert Packer

Hospital

06/21/2019

06/20/2019 Office Visit Schutt, Lynn, NP Outpatient
GAD (generalized anxiety disorder) (Primary Dx)

SAYRE

06/20/2019

Progress Notes - Schutt, Lynn, NP - 06/20/2019 3:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 6/20/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with
• Anxiety

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.
HPI

Comes to office today for increasing anxiety over past few months.

She states she recently had shoulder surgery 5/24/2019, prior to going off to have surgery she states her anxiety had increased due to the increased stress brought on by her boss to the point where she has recently resigned from her position because of this. She does state she also "have a lot going on in my personal life also, but with what I was going through at work I can't go back there."

Pt denied suicidal ideation, plan, and intent. Pt denied previous history of suicide attempts. Pt does not present as an imminent risk.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- Anxiety

- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father

?Marfan's Syndrome

- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather

- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluconazole (DIFLUCAN) 200 MG Oral Tab Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- gabapentin (NEURONTIN) 300 MG Oral Cap Take 1 Cap by mouth EVERY BEDTIME.
- HYDROcodone-acet aminophen (NORCO) 5-325 MG Oral Tab Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (Pain, continued treatment). Max Daily Amount: 6 Tabs.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- OXYcodone (OXY-IR,OXY-FAST) 5 MG Oral Tab Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (pain). Max Daily Amount: 30 mg.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file

Date	Type	Specialty	Care Team	Description
	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 340 of 1112			EXHIBIT NO. B2F PAGE: 12 OF 309
	<ul style="list-style-type: none"> • Number of children: Not on file • Years of education: Not on file • Highest education level: Not on file Occupational History <ul style="list-style-type: none"> • Not on file Social Needs <ul style="list-style-type: none"> • Financial resource strain: Not on file • Food insecurity: Worry: Not on file Inability: Not on file <ul style="list-style-type: none"> • Transportation needs: Medical: Not on file Non-medical: Not on file Tobacco Use <ul style="list-style-type: none"> • Smoking status: Never Smoker • Smokeless tobacco: Never Used Substance and Sexual Activity <ul style="list-style-type: none"> • Alcohol use: No Alcohol/week: 0.0 oz <ul style="list-style-type: none"> • Drug use: No • Sexual activity: Yes Partners: Male Birth control/protection: Pill, Condom Comment: OCPs Lifestyle <ul style="list-style-type: none"> • Physical activity: Days per week: Not on file Minutes per session: Not on file <ul style="list-style-type: none"> • Stress: Not on file Relationships <ul style="list-style-type: none"> • Social connections: Talks on phone: Not on file Gets together: Not on file Attends religious service: Not on file Active member of club or organization: Not on file Attends meetings of clubs or organizations: Not on file Relationship status: Not on file <ul style="list-style-type: none"> • Intimate partner violence: Fear of current or ex partner: Not on file Emotionally abused: Not on file Physically abused: Not on file Forced sexual activity: Not on file Other Topics Concern <ul style="list-style-type: none"> • Not on file Social History Narrative August 2016: Works at Guthrie GI department. Lives with husband, has no children. 			

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative.

HENT: Negative for congestion, ear pain, hearing loss, sinus pain, sore throat and tinnitus.

Eyes: Negative for blurred vision, double vision, photophobia, discharge and redness.

Respiratory: Negative for cough, shortness of breath, wheezing and stridor.

Cardiovascular: Negative for chest pain, palpitations and leg swelling.

Gastrointestinal : Positive for abdominal pain (intermittent, hx of crohn's).

Genitourinary: Negative.

Musculoskeletal: Positive for joint pain (hx of RA). Negative for back pain, falls and myalgias.

Skin: Negative.

Neurological: Negative.

Endo/Heme/Allerg ies: Negative.

Psychiatric/Beha vioral: Negative for **hallucinations**, substance abuse and **suicidal** ideas. The patient is nervous/anxious (increased over past few months).

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 341 of 1112				EXHIBIT NO. B2F PAGE 13 OF 309
Objective				
PHYSICAL EXAM:				
VITALS: BP 118/80 (BP Location: Right arm, Patient Position: Sitting) Pulse 102 Temp 100 °F (37.8 °C) (Tympanic) Resp 18 Ht 5' 11" (1.803 m) Wt 286 lb (129.7 kg) SpO2 97% BMI 39.89 kg/m² Body mass index is 39.89 kg/m².				
Physical Exam				
Constitutional: She is oriented to person, place, and time. Vital signs are normal. She appears well-developed and well-nourished.				
HENT:				
Head: Normocephalic and atraumatic.				
Right Ear: Hearing and external ear normal.				
Left Ear: Hearing and external ear normal.				
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and lids are normal.				
Neck: Normal range of motion.				
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.				
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. She has no wheezes. She has no rhonchi. She has no rales.				
Musculoskeletal: Normal range of motion.				
Neurological: She is alert and oriented to person, place, and time. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.				
Skin: Skin is warm, dry and intact.				
Psychiatric: Her speech is normal and behavior is normal. Judgment and thought content normal. Her mood appears anxious. Cognition and memory are normal. She expresses no <u>homicidal</u> and no <u>suicidal</u> ideation. She expresses no <u>suicidal</u> plans and no <u>homicidal</u> plans.				

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. GAD (generalized anxiety disorder) 300.02 F41.1

Plan

1. Xanax 0.25mg TID PRN for anxiety

T/C made to employee health. Patient will report there after appointment today to be evaluated.

EAP phone number given to patient. She does have strong supportive family at home she is able to rely on.

Pt denied suicidal ideation, plan, and intent. Pt denied previous history of suicide attempts. Pt does not present as an imminent risk.

List of community recourses given to patient at time of discharge.

Discussed with patient to not take hydrocodone and Xanax together. Understanding stated by patient.

She will f/u in one week with PCP

Discussed with patient should her anxiety increase and she develops thoughts of suicide/homicide , hurting herself or others she will call 911 or go to the nearest ED.

Patient aware and agreeable to plan of care.

Author: Lynn Schutt, NP 6/20/2019 16:11

Electronically signed by Schutt, Lynn, NP at 06/20/2019 4:47 PM EDT

Lab

SAYRE
06/06/2019

Generalized abdominal pain;
Crohn's disease with
complication, unspecified
gastrointestinal tract neoplasm
(HCC);
Low vitamin D level

SAYRE
06/06/2019

Progress Notes - Watson, Brittany, PA - 06/06/2019 10:00 AM EDT

Formatting of this note might be different from the original.

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 6/6/2019

Chief Complaint

Patient presents with

- Follow Up

2weeks s/p LSSAD/DCE 5/24/19 Patient has some soreness, overall doing well. Steristrips fell off on there own.

HPI: Jennifer Lyn Brown is a 42-y.o. female who is here for follow up 2 weeks status post left shoulder subacromial decompression, distal clavicle excision. The patient reports that she has discontinued her sling and is doing pendulum exercises. Pain is under good control with current pain medication regimen. Was switched to norco due to rash she was experiencing after taking percocet. Rash is resolving. Denies tingling, burning, numbness distally.

Physical Exam:

Shoulder: Incisions healing well without any evidence of erythema, edema, drainage.

Neurological: Sensation intact distally.

Vascular: Radial pulse present.

Impression:

ICD-9-CM ICD-10-CM

1. Orthopedic aftercare V54.9 Z47.89

Plan:

Her questions and concerns were addressed and answered to her satisfaction. She may remain out of sling. Begin motion and strengthening exercises as demonstrated on handouts. No lifting, pushing, pulling. She will follow up in 4 weeks or sooner if necessary.

Author: Brittany Watson, PA 6/6/2019 11:07

Electronically signed by Watson, Brittany, PA at 06/06/2019 11:08 AM EDT

Nursing Note - Albers, Nichole, LPN - 06/06/2019 10:00 AM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 6/6/2019

CONSTITUTIONAL: negative.

HEENT: negative.

EYES: negative

RESPIRATORY: negative.

CARDIOVASCULAR: negative.

GASTROINTESTINAL : negative.

GENITOURINARY: negative.

INTEGUMENT/BREAS T: negative.

HEMATOLOGIC/LYMP HATIC: negative.

MUSCULOSKELETAL: negative except 2weeks s/p LSSAD/DCE 5/24/19 Patient has some soreness, overall doing well. Steristrips fell off on there own.

Body mass index is 39.89 kg/m². Patient aware

AUTHOR: Nichole Albers, LPN 6/6/2019 10:11

Electronically signed by Albers, Nichole, LPN at 06/06/2019 10:11 AM EDT

06/06/2019 Telephone Shaw, Beth, RN Follow Up

SAYRE
06/06/2019

Telephone Encounter - Shaw, Beth, RN - 06/06/2019 2:28 PM EDT

Patient last seen in GI office by Dr.Georgetson 11/15/18. Last labs 6/6/19. Dr.Georgetson, please sign 3 month labs if in agreement.

Lori, please schedule patient to see Dr.Georgetson or NP for follow up care on Stelara. Patient will need nurse visit scheduled for next Stelara injection (teaching with significant other), once cleared by Orthopedics to resume.

Electronically signed by Shaw, Beth, RN at 06/06/2019 2:36 PM EDT

Telephone Encounter - Bentley, Lori - 06/06/2019 3:11 PM EDT

Called PT left msg to call office back needs to be sched for F/U appt for care on Stelara

Electronically signed by Bentley, Lori at 06/06/2019 3:12 PM EDT

Telephone Encounter - Shaw, Beth, RN - 06/13/2019 10:08 AM EDT

Please review and sign orders for 3 month labs. Last drawn 6/6/19. Thanks.

Electronically signed by Shaw, Beth, RN at 06/13/2019 10:12 AM EDT

05/24/2019 Surgery Choi, Joseph, MD

Robert Packer
Hospital
05/24/2019
LEFT SHOULDER
ARTHROSCOPIC
SUBACROMIAL
DECOMPRESSION, DISTAL
CLAVICLE EXCISION

05/24/2019 Anesthesia Event Chopra, Nitin, MD
Uddoh, Emmanuel, MD

Robert Packer Hospital
05/24/2019

Anesthesia Preprocedure Evaluation - Uddoh, Emmanuel, MD - 05/21/2019 3:50 PM EDT

Formatting of this note might be different from the original.

Anesthesia Evaluation

no history of anesthetic complications

Pulmonary:

sleep apnea, CPAP Cardiovascular:

Dyspnea/SOB.

FINAL IMPRESSION:

Normal left heart size with normal LV systolic function and no regional wall motion abnormalities; estimated LVEF 55-60%.

Normal right heart size and RV systolic function.

No structurally or hemodynamically significant valvular disease.

No pericardial effusion.

Compared to resting portion of prior stress echo report 4/15/13, no significant changes are apparent.

Neuro/Psych:

depression

ADHD

Fibromyalgia

anxiety/panic attacks GI/Hepatic:

GERD

liver disease (Fatty Liver)

Gastroparesis

IBS

S/p Bariatric Surgery

Endo/Heme/Other:

Patient is obese.

Morbidly obese

arthritis (Rheumatoid Arthritis)

Impingement Syndrome (L) Shoulder

Renal:

negative renal ROS

Infectious Disease:

infectious disease ROS negative

Physical Exam

Airway:

Mallampati: II

TM distance: >3 FB

Neck ROM: Full, flexion and extension

Interdental Distance: Normal

Cardiovascular:

cardiovascular exam normal

Dental:

no notable dental history- normal exam

Pulmonary:

breath sounds clear to auscultation

Other **Findings**:

Anesthesia Plan

Plan: general and regional
ISB

Induction: intravenous

Informed Consent; Options, Procedures and Risks, including oral trauma and Anesthetic plan discussed with: patient

Blood Products:

Discussed plan with:
CRNA and surgeon

Principal **Diagnosis**: Impingement syndrome of left shoulder

Electronically signed by Chopra, Nitin, MD at 05/24/2019 7:16 AM EDT

Anesthesia Procedure Notes - Chopra, Nitin, MD - 05/24/2019 7:41 AM EDT

Nerve Block

Date/Time: 5/24/2019 7:34 AM

Performed by: Chopra, Nitin, MD

Authorized by: Chopra, Nitin, MD

Universal protocol

Consent obtained: Written
Consent provided by: Patient -
Risks/benefits discussed with: Patient -

Time out performed: Yes
Consents match procedure: Yes

Pre-Procedure
Indications: post-op pain management

Preadmission anticoagulation **therapy**:

Location

Body area: Upper extremity

Upper Extremity: Interscalene

Sedation/Analgesia
Yes

Level of sedation:
Sedation type: anxiolysis
Sedation: Midazolam and see MAR for details

Vital signs monitored during sedation Vital signs monitored during sedation

Procedure Details
Preparation: Patient was prepped and draped in usual sterile fashion
Prep Solution: Chloraprep
Patient position: Beach chair
Skin Infiltration Drug: lidocaine 1%
Needle gauge: 22 G
Needle type: Echogenic

Location technique: Ultrasound guidance

Local anesthetic: Ropivacaine 0.5%

Anesthetic total (ml): 25

Injection Made Incrementally in mL: 2

Post procedure

Outcome/Complications: Positive block

Patient tolerance: Patient tolerated the procedure well with no immediate complications

Vitals monitored during the procedure: Patient observed

Comments

Electronically signed by Chopra, Nitin, MD at 05/24/2019 7:42 AM EDT

Anesthesia Postprocedure Evaluation - Johnson, Glen, MD - 05/24/2019 10:34 AM EDT

Formatting of this note might be different from the original.

ANESTHESIA POST-OP NOTE

Robert Packer Hospital

1 GUTHRIE SQUARE

SAYRE PA 18840

570-888-6666

Name: Jennifer Lyn Brown MRN: 340616

DOB: 10/26/1976 Age: 42-y.o.

VISIT#: 110417193

ADMISSION DATE: 5/24/19

Anesthesiologist :Chopra, Nitin, MD

Anesthesia Type: general, regional

ASA: Two

Last Vitals:

Vitals Value Taken Time

BP 120/64 5/24/2019 10:25 AM

Temp 97.9 °F (36.6 °C) 5/24/2019 9:33 AM

Pulse 78 5/24/2019 10:25 AM

Resp 14 5/24/2019 9:33 AM

SpO2 93 % 5/24/2019 10:25 AM

Mental Status recovered; pt participates in eval: Yes

Vital Signs Stable:Yes

Pain control satisfactory: Yes

Respiratory function stable airway patent: Yes

Cardio Function and hydration stable: Yes

N&V control adequate:Yes

Extremity sensation/strength as expected for given anesthetic:Yes

Pt recovered without intra-op awareness: Yes

Pt recovered without apparent anesthesia complication: Yes

Author: Glen Johnson, MD 5/24/2019

Electronically signed by Johnson, Glen, MD at 05/24/2019 10:34 AM EDT

Hospital Encounter

Choi, Joseph, MD

Short Procedure

Robert Packer Hospital

05/24/2019

EXHIBIT NO. B2F

PAGE: 19 OF 309

H&P (View-Only) - Choi, Joseph, MD - 05/06/2019 11:30 AM EDT

Formatting of this note might be different from the original.

GUTHRIE SP/OP BRIEF H&P

1 GUTHRIE SQUARE
SAYRE PA 18840-1625
570-888-5858

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DOS: See records

Chief Complaint: left shoulder pain

Past History: see records

Surgery: left shoulder subacromial decompression, distal clavicle excision

Allergies/Reaction: See records

Medications:

Outpatient Medications Marked as Taking for the 5/6/19 encounter (Office Visit) with Choi, Joseph, MD

Medication Sig Dispense Refill

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY. 90 Tab 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY. 60 Tab 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY. 90 Cap 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. 12 mL 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. 42 Tab 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting). 1 Each 3
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. 8 Cap 1
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY. 1 Bottle 0
- folic acid 1 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 5
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS. 100 Each 0
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate 100 Each 1
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly 100 Each 0
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. 84 Tab 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. 90 Tab 1
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. 12 mL 1
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. 1 Tube 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. 30 Tab 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. 90 Tab 1
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn 60 Cap 3
- [DISCONTINUED] sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY. 120 Tab 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS Inject 1 mL of Vit B12 IM every 30 days 12 Each 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. 1 Syringe 5

Current Facility-Adminis tered Medications for the 5/6/19 encounter (Office Visit) with Choi, Joseph, MD
Medication Dose Route Frequency Provider Last Rate Last Dose
• saline (OCEAN) nasal spray 0.65 % 2 Spray Nasal Q2H PRN Braslow, Matthew Lim, DO

PHYSICAL EXAM:

Vital Signs on nurses notes, and patient stable
Skin intact
Neurovascularly intact
Lungs: CTA bilateral
CV: RRR

Plan: Proceed with scheduled procedure. Risks include but not limited to bleeding, infection, nerve damage, compartment syndrome, wound healing problems, blood clots, lung clots, loss of limb, fracture, death, need for further surgery, hardware complications and anesthetic complications. Benefits are decreased pain.

Author: Joseph Choi, MD 5/8/2019

Electronically signed by Choi, Joseph, MD at 05/08/2019 8:56 AM EDT

Physical Appearance - Rockwell, Janaye B, RN - 05/24/2019 6:31 AM EDT

Formatting of this note might be different from the original.

110417193
Robert Packer Hospital
RPH PREPROCEDURE
Nursing Physical Appearance Note

Name: Jennifer Lyn Brown MRN: 340616
DOB: 10/26/1976 Age: 42-y.o.

Physical Exam
Constitutional:

Electronically signed by Rockwell, Janaye B, RN at 05/24/2019 6:32 AM EDT

Interval H&P Note - Choi, Joseph, MD - 05/24/2019 7:33 AM EDT

I have reviewed the H&P and examined the patient. No changes have occurred unless otherwise indicated. Joseph Choi, MD
5/24/2019

Electronically signed by Choi, Joseph, MD at 05/24/2019 7:33 AM EDT

Op Note - Choi, Joseph, MD - 05/24/2019 9:25 AM EDT

OPERATIVE NOTE

RPH/Guthrie Clinic
Sayre PA

Name: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of procedure: 5/24/19

Preoperative **diagnosis:**

Postoperative **diagnosis**: Same

Procedure:

1. Arthroscopic subacromial decompression with acromioplasty and distal clavicle excision-left

Attending: Joseph Choi, MD, PhD

Assistant: Nick Marsiglio, PA. Due to the complicated nature of this case an assistant was necessary. His/her help was invaluable to the completion of this case.

Implants:

None

Tubes/Drains: none

Estimated Blood Loss: minimal

Antibiotics: See records

Anesthesia:

1. General endotracheal anesthesia
2. Interscalene block

Complications: none

Sponge and needle counts: correct

Indications for procedure:

Having failed conservative care, this patient opted for operative intervention. The risks and benefits are discussed in my pre operative **history and physical**. Informed consent was obtained. Medical clearance was obtained if necessary.

Procedure:

The patient was identified in the waiting area. The left shoulder was marked, and the consent form and history/physical was reviewed. This was consistent with what we planned on doing. The anesthesia staff administered antibiotics and an interscalene block. Afterwards the patient was brought to the operating room where a second time out was done consistent with hospital protocol. After general anesthesia was administered, the patient was placed in a T-Max head holder in the beach chair position. All prominences were well padded. Range of motion was normal. There was no instability. After prepping and draping the shoulder, a standard posterior portal was placed and a diagnostic arthroscopy was performed. The glenoid cartilage was intact. The humeral head cartilage was intact. The biceps tendon was intact. The labrum was intact. The visualized articular portion of the rotator cuff was intact. The subscapularis was intact. An extensive intra articular debridement was not needed. After the intra articular part was completed, the camera was placed into the subacromial space and a lateral portal was established using a spinal needle as a guide. I placed the camera from the side and from the back, through a 7 mm screw-in cannula, I did a thorough subacromial decompression. Extensive bursitis was present. I also partially resected the undersurface of the coracoacromial ligament and exposed a small but prominent spur on the undersurface of the acromion. This was removed with a burr in reverse. After the acromioplasty was performed, I inspected the bursal side of the rotator cuff tendons. They were intact. No tear was present. I established an anterior portal with an aid of a spinal needle for the distal clavicle resection. Soft tissue was cleared underneath as well as in the acromioclavicular joint. Debris was removed with a shaver. Using a burr I removed lateral clavicle as well as bone from the acromial side. The distal clavicle excision was uniformed when viewed with the 70 degree as well as the 30 degree arthroscope. We had enough room in the acromioclavicular joint-approximately 8 mm of space. There is no abutment with cross adduction testing. Afterwards, the arthroscopy was terminated, and the wounds were closed. Bulky dressing was applied and a sling was placed. The patient was brought to the recovery room in good condition.

Postoperative course:

Patient will be in a sling for comfort. Activity as tolerated. Pain medication as prescribed. My standard discharge sheet was given to the patient.

Electronically signed by Choi, Joseph, MD at 05/24/2019 9:30 AM EDT

Nursing Discharge - Millard, Amy, RN - 05/24/2019 11:00 AM EDT

Name: Jennifer Lyn Brown MRN: 340616
 DOB: 10/26/1976 Age: 42-y.o.

APIE: Discharge instructions given regarding nerve block, activity restrictions dressing changes, f/u appointments and prescriptions with understanding verbalized. Amy Millard RN

Amy Millard, RN

Electronically signed by Millard, Amy, RN at 05/24/2019 11:01 AM EDT

Discharge Summary - Marsiglio, Nicolas, RPA-C - 05/24/2019 11:25 AM EDT

GUTHRIE SP/OP DISCHARGE NOTE
 Robert Packer Hospital
 1 GUTHRIE SQUARE
 SAYRE PA 18840
 570-888-6666

PATIENT: Jennifer Lyn Brown
 SURGEON: Primary: Choi, Joseph, MD
 ASSISTING: Nicolas Marsiglio, RPA-C
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SURGERY: 5/24/2019

Procedure: left shoulder arthroscopy, distal clavicle excision

Principle **Diagnosis:** impingement syndrome and acromioclavicular joint arthritis - left

Associated Condition(s): Same as pre-op, unless otherwise indicated

Mental Status: Same as pre-op, unless otherwise indicated.

Condition: Stable, unless otherwise indicated

Disposition of Care: Discharge to home.

Appointment with/ or Follow-up with Dr. Joseph Choi 2 weeks.

No orders of the defined types were placed in this encounter.

Other Comments: see discharge instructions

Author: Nicolas Marsiglio, RPA-C 5/27/2019

05/24/2019	Electronically signed by Choi, Joseph, MD at 05/28/2019 4:17 PM EDT	
05/23/2019	Orders Only	Choi, Joseph, MD
	Telephone	Seeley, Kelly

SAYRE 05/23/2019

Telephone Encounter - Seeley, Kelly - 05/23/2019 1:37 PM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 5/23/2019

Called patient with surgical report time and patient answered and confirmed.

Author: Kelly Seeley 5/23/2019 13:37

Electronically signed by Seeley, Kelly at 05/23/2019 1:38 PM EDT

05/20/2019 Telephone Young, Felicia No Show

SAYRE
05/20/2019

Telephone Encounter - Young, Felicia - 05/20/2019 9:08 AM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 5/20/2019

Dr. Gillan,
This patient was scheduled to see you on 05/17/2019 and did show for the appointment. A no show letter has been sent.

Author: Felicia Young 5/20/2019 09:08

Electronically signed by Young, Felicia at 05/20/2019 9:08 AM EDT

Telephone Encounter - Gillan, Michael F, DO - 05/20/2019 9:46 AM EDT

Name: Jennifer Lyn Brown
DOB: 10/26/1976
MRN: 340616
Date of Service: 5/20/2019

Noted, thank you.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 05/20/2019 9:46 AM EDT

05/15/2019 Office Visit Braund, Lisa, FNP-C Sore throat (Primary Dx);
Acute pharyngitis, unspecified etiology;
Fever, unspecified fever cause;
Referred otalgia, unspecified laterality

SAYRE
05/15/2019

Progress Notes - Braund, Lisa, FNP-C - 05/15/2019 7:10 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 5/15/2019

Chief Complaint

Patient presents with

- Sore Throat
- Ear Pain
- Sinus Problem

pressure

HPI: Jennifer Lyn Brown is 42-y.o. and presents today with complaints of sore throat.
Symptoms started: yesterday suddenly
Remedies tried: tylenol
Known exposure to someone with strep/recent illness: Yes, a coworker with strep currently.
Associated symptoms include: fever, ear pain, sinus pressure
Is there a History of tonsillectomy: yes
Denies: Cough, abdominal pain, nausea, vomiting, excessive fatigue

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD N/A
- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2013 with liver **biopsy**
- PR CLOSED RX TARSAL FX, EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014 for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
- TONSILLECTOMY 11/26/07

Outpatient Medications Marked as Taking for the 5/15/19 encounter (Office Visit) with Braund, Lisa, FNP-C
Medication Sig Dispense Refill

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY. 90 Tab 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY. 60 Tab 5
- Cefdinir (OMNICEF) 300 MG Oral Cap Take 1 Cap by mouth TWICE DAILY for 10 days. 20 Cap 0
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY. 90 Cap 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. 12 mL 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. 42 Tab 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting). 1 Each 3
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. 8 Cap 1
- fluconazole (DIFLUCAN) 200 MG Oral Tab Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10 2 Tab 0
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY. 1 Bottle 0
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 5
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS. 100 Each 0
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate 100 Each 1
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly 100 Each 0
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. 84 Tab 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. 90 Tab 1
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. 12 mL 1
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. 1 Tube 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. 30 Tab 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. 90 Tab 1
- predniSONE (DELTASONE) 5 MG Oral Tab Take 4 Tabs by mouth DAILY for 5 days, THEN 3 Tabs DAILY for 5 days, THEN 2 Tabs DAILY for 5 days, THEN 1 Tab DAILY for 5 days. Then STOP. 50 Tab 0
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn 60 Cap 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days 12 Each 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. 1 Syringe 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. 90 Cap 1
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. 90 Cap 1

Current Facility-Adminis tered Medications for the 5/15/19 encounter (Office Visit) with Braund, Lisa, FNP-C
Medication Dose Route Frequency Provider Last Rate Last Dose

- saline (OCEAN) nasal spray 0.65 % 2 Spray Nasal Q2H PRN Braslow, Matthew Lim, DO

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

ROS: Reviewed in HPI and pertinent positives noted above, remaining are negative if not otherwise stated.

GENERAL: Alert, appears mildly ill.
 HEAD: Atraumatic
 EYES: Without redness or drainage.
 EARS: Bilateral canals healthy and clear. Tympanic membrane's non-erythematus with good light return bilaterally.
 NOSE: Pink and moist nasal mucosa. Mild clear rhinorrhea.
 FACE: No facial swelling or pain
 ORAL CAVITY: Pink & moist oral mucosa. Tonsils absent, + erythema, + petechial hemorrhages on posterior soft palate.
 Uvula midline. No trismus.
 NECK: +small, mildly tender anterior cervical lymphadenopathy bilaterally <1cm. Tenderness bilateral submandibular glands but no swelling. Trachea midline. No stridor.
 CHEST/LUNGS: Resps easy and unlabored. Clear to auscultation bilaterally. No wheezes, rales, rhonchi.
 HEART: Regular rate and rhythm. No abnormal heart sounds appreciated
 INTEGUMENTARY: Skin pink, warm, without edema, acute rashes or lesions noted.

PROCEDURES:

Results for orders placed or performed in visit on 05/15/19
 STREP A ANTIGEN (AMB POCT)
Result Value Ref Range
 Strep A Antigen (POCT) Negative Negative

ASSESSMENT:

ICD-9-CM ICD-10-CM
 1. Sore throat 462 J02.9 STREP A ANTIGEN (AMB POCT)
 THROAT STREP SCREEN CULTURE
 THROAT STREP SCREEN CULTURE
 2. Acute pharyngitis, unspecified etiology 462 J02.9
 3. Fever, unspecified fever cause 780.60 R50.9
 4. Referred otalgia, unspecified laterality 388.72 H92.09

Concern for strep
 Is scheduled for shoulder surgery next week

PLAN:

Patient Instructions

Omnicef 300mg twice daily x 10 days
 Diflucan as needed

Warm salt water gargles.

Ibuprofen/tyleno I as needed for pain/fever.

Rest
 Fluids

Be sure to obtain new tooth brush after appx 24-48 hours on antibiotics

Rapid strep today was: negative, however, I am suspicious it may be positive in 2 days
 Throat culture will be sent for final evaluation and **results** available in 2-3 days.
 If anything different shows than today's **results**, we will contact you, or you may contact us at 570.887.2383 for **results**.

Recheck in 3-4 days, or sooner if symptoms persist or worsen.

Lisa Braund, FNP-C 5/15/2019 07:50

Electronically signed by Braund, Lisa, FNP-C at 05/15/2019 7:50 AM EDT

Nursing Note - Rider, Terri, LPN - 05/15/2019 7:10 AM EDT

Chief Complaint

Patient presents with

- Sore Throat
- Ear Pain
- Sinus Problem pressure
- Fever 100.9
- Eye Problem left "eye pain"

Author: Terri Rider, LPN 5/15/2019 07:20

Electronically signed by Rider, Terri, LPN at 05/15/2019 7:22 AM EDT
Telephone Kaysa, Mary Other

SAYRE
05/15/2019

Telephone Encounter - Kaysa, Mary - 05/15/2019 4:00 PM EDT

Jen called regarding the MR ABD of PELVIS ENTEROGRAPHY that Dr. Georgetson wants her to have before surgery. **Imaging** does not have an opening to get this done she wanted me to let you know. Also, she will call and/or check on line for any cancellation. Please let me know if I can do anything. Thanks

Electronically signed by Kaysa, Mary at 05/15/2019 4:07 PM EDT

Telephone Encounter - Shaw, Beth, RN - 05/15/2019 4:19 PM EDT

Writer called radiology department to inquire about a wait list or cancellation list for patient to get MR Enterography performed asap d/t having surgery 5/24/19. Per radiology, no availability to perform **MRI** prior to 5/24/19, no wait list or cancellation list. Per radiology, patient is encouraged to call each morning in attempt to get appointment if a cancellation appointment opens up.
Message left on patient's voicemail to call each day.
Please advise if other recommendations. Thanks.

Electronically signed by Shaw, Beth, RN at 05/15/2019 4:25 PM EDT

Telephone Encounter - Georgetson, Michael J, MD FACG - 05/15/2019 4:59 PM EDT

Noted. Is there availability at any other Guthrie site?

Electronically signed by Georgetson, Michael J, MD FACG at 05/15/2019 4:59 PM EDT

Telephone Encounter - Bentley, Lori - 05/16/2019 12:17 PM EDT

Spoke to patient and she is going to keep checking for and cancellations, she did try for other Guthrie Facilitys for sooner appt but nothing available yet

Electronically signed by Bentley, Lori at 05/16/2019 12:18 PM EDT

Telephone Shaw, Beth, RN Other

SAYRE
05/13/2019

Telephone Encounter - Shaw, Beth, RN - 05/13/2019 3:45 PM EDT

Patient placed on Prednisone 5/9/19. Having shoulder surgery 5/24/19. Please advise, thanks.

Dr.Georgetson,

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 356 of 1112				
				"So I am having some tingling in my physical doc feels it's just like I am with age so not a shoulder on the face. I just have pain in my side- lower and upper still. Checked my temp- it's 100.0- not bad, but still up for me and obviously still taking the Prednisone. Checked with OB too because I have a cyst on my ovary, but OB seems to think it is not related and would not cause my temp to go up. Their concern was that I am on Methotrexate. My only concern is my upcoming shoulder surgery". Thanks- Jen
				Electronically signed by Shaw, Beth, RN at 05/13/2019 3:48 PM EDT
				Telephone Encounter - Georgetson, Michael J, MD FACG - 05/14/2019 5:13 PM EDT
				Her surgery is coming up soon
				If she is still having issues a MR enterography would be reasonable. She did have a pelvic MR but this was not optimized for the GI tract.
				At the date of the MRE, get a cbc, cmp, esr, crp
				Electronically signed by Georgetson, Michael J, MD FACG at 05/14/2019 5:14 PM EDT
				Telephone Encounter - Shaw, Beth, RN - 05/15/2019 9:35 AM EDT
				Orders pended. Please review and sign. No answer, message left for patient to return call. Patient needs informed of Dr.Georgetson's recommendations.
				Electronically signed by Shaw, Beth, RN at 05/15/2019 10:13 AM EDT
				Telephone Encounter - Shaw, Beth, RN - 05/15/2019 3:12 PM EDT
				Patient informed of Dr.Georgetson's recommendations. Encouraged to have blood work completed as soon as possible. Request for imaging given to Lori Bentley to schedule. Patient states she went to see Lisa Braund this morning and is being treated for strep infection. Patient states her abdominal pain is a little better today.
				Electronically signed by Shaw, Beth, RN at 05/15/2019 3:18 PM EDT
05/09/2019	Telephone		Shaw, Beth, RN	Orders (lab And Procedure)
<div> <div>SAYRE</div> <div>05/09/2019</div> </div>				
				Telephone Encounter - Shaw, Beth, RN - 05/09/2019 12:29 PM EDT
				Patient with abdominal pain, off Stelara for impending shoulder surgery in 2 weeks. Per Dr.Georgetson's request, via patient's e-guthrie, order pended for Prednisone. Please review and sign. Thanks.
				Per Dr.Georgetson: "Tylenol prn is safe, I would avoid NSAIDs If needed we could give a short course of prednisone. Given the upcoming surgery I would suggest we use 20 mg daily and reduce by 5 mg each 5 days".
				Electronically signed by Shaw, Beth, RN at 05/09/2019 12:39 PM EDT
				Telephone Encounter - McDonald, Thomas J, MD - 05/09/2019 12:49 PM EDT
				Done.
				Electronically signed by McDonald, Thomas J, MD at 05/09/2019 12:50 PM EDT
				Telephone Encounter - Shaw, Beth, RN - 05/09/2019 1:30 PM EDT
				Patient informed of Dr.Georgetson's recommendations and that Prednisone prescription e-scribed to Clinic Pharmacy. Patient verbalized understanding and agreement.
				Electronically signed by Shaw, Beth, RN at 05/09/2019 1:32 PM EDT
05/06/2019	Hospital Encounter			Outpatient

05/06/2019

EXHIBIT NO. B2F

Pre-Procedure Instructions - Millard, Cindy, RN - 05/06/2019 2:23 PM EDT

PAGE: 29 OF 309

PAT teaching done including NPO status, correct use of surgical soap, high protein diet, pt verbalizes understanding.
Instruction sheet from office reviewed, pt denies concerns or questions.

Electronically signed by Millard, Cindy, RN at 05/06/2019 2:23 PM EDT

05/06/2019 Office Visit

Choi, Joseph, MD

Arthritis of left acromioclavicular joint (Primary Dx)

SAYRE**05/06/2019****Progress Notes** - Choi, Joseph, MD - 05/06/2019 11:30 AM EDT

Formatting of this note might be different from the original.

GUTHRIE SP/OP BRIEF H&P

1 GUTHRIE SQUARE
SAYRE PA 18840-1625
570-888-5858

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DOS: See records

Chief Complaint: left shoulder pain

Past History: see records

Surgery: left shoulder subacromial decompression, distal clavicle excision

Allergies/Reaction: See records

Medications:

Outpatient Medications Marked as Taking for the 5/6/19 encounter (Office Visit) with Choi, Joseph, MD

Medication Sig Dispense Refill

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY. 90 Tab 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY. 60 Tab 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY. 90 Cap 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. 12 mL 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. 42 Tab 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting). 1 Each 3
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. 8 Cap 1
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY. 1 Bottle 0
- folic acid 1 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 5
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS. 100 Each 0
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate 100 Each 1
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly 100 Each 0
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. 84 Tab 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. 90 Tab 1
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. 30 Tab 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. 12 mL 1
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. 1 Tube 0

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LCS Document 18 Filed 02/27/23 Page 35 of 142	ondansetron (N/V) 8 MG Oral Tab EC Take 1 Tab by mouth DAILY. 30 Tab 1	NEEDED for nausea. 30 Tab 1		EXHIBIT NO. B2F PAGE: 30 OF 309
	pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. 90 Tab 1			
	Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn 60 Cap 3			
	[DISCONTINUED] sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY. 120 Tab 3			
	Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days 12 Each 0			
	Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. 1 Syringe 5			
	venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. 90 Cap 1			
	venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. 90 Cap 1			

Current Facility-Adminis tered Medications for the 5/6/19 encounter (Office Visit) with Choi, Joseph, MD
Medication Dose Route Frequency Provider Last Rate Last Dose

- saline (OCEAN) nasal spray 0.65 % 2 Spray Nasal Q2H PRN Braslow, Matthew Lim, DO

PHYSICAL EXAM:

Vital Signs on nurses notes, and patient stable

Skin intact

Neurovascularly intact

Lungs: CTA bilateral

CV: RRR

Plan: Proceed with scheduled procedure. Risks include but not limited to bleeding, infection, nerve damage, compartment syndrome, wound healing problems, blood clots, lung clots, loss of limb, fracture, death, need for further surgery, hardware complications and anesthetic complications. Benefits are decreased pain.

Author: Joseph Choi, MD 5/8/2019

Electronically signed by Choi, Joseph, MD at 05/08/2019 8:56 AM EDT

Nursing Note - Yanchuk, Ashley, ST - 05/06/2019 11:30 AM EDT

NAME: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 5/6/2019

CONSTITUTIONAL: negative.

HEENT: negative.

EYES: negative.

RESPIRATORY: negative.

CARDIOVASCULAR: negative.

GASTROINTESTINAL : negative.

GENITOURINARY: negative.

INTEGUMENT/BREAS T: negative.

HEMATOLOGIC/LYMP HATIC: negative.

MUSCULOSKELETAL: Positive left shoulder preop.

NEUROLOGICAL: negative.

BEHAVIORAL/PSYCH : negative.

ENDOCRINE: negative.

ALLERGIC/IMMUNOL OGIC: Negative.

Body mass index is 39.89 kg/m². Patient is aware.

AUTHOR: Ashley Yanchuk, ST 5/6/2019 12:55

Electronically signed by Yanchuk, Ashley, ST at 05/06/2019 1:39 PM EDT

Telephone

Gillan, Michael F, DO

354

SAYRE

Name: Jennifer Lyn Brown
 DOB: 10/26/1976
 MRN: 340616
 Date of Service: 5/2/2019

Patients sleep study shows she needs CPAP at 10 cm pressure.
 Sent to Medical Supply, please inform patient.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 05/02/2019 11:32 AM EDT

Telephone Encounter - Prough, Shannon, LPN - 05/02/2019 12:53 PM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 5/2/2019

Patient notified via eguthrie.

Author: Shannon Prough, LPN 5/2/2019 12:53

Electronically signed by Prough, Shannon, LPN at 05/02/2019 12:53 PM EDT

Hospital Encounter

Outpatient

Robert Packer Hospital

04/28/2019

Progress Notes - Tigue, Yvonne - 04/28/2019 11:59 PM EDT

Formatting of this note might be different from the original.

Guthrie Sleep Disorders Center
 RPH Sleep Lab
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4639

Patient: Jennifer Lyn Brown
 MRN: 340616
 Date of birth: 10/26/1976
 Study Type: CPAP
 Date of test: 4/28/2019
 Technician: Yvonne Tigue,RPSGT
 Room #: 1
 Acq #: 1001319

Pre-Testing Questionnaire

- 1) What time did you fall asleep last night? 930pm
- 2) What time did you wake up this morning? 10am
- 3) Was this a typical night's sleep for you? yes
 If no, please explain: Day off this is normal
- 4) Approximately how many hours did you sleep...
 Last night 8-9
 Two nights ago 8-9
 Three nights ago 6-7
- 5) How many naps did you have today? 0
 How long?

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 360 of 1112				
	6)	How tired/sleepy are you now? Wake awake in the morning, eyes open =		EXHIBIT NO. B2F PAGE: 32 OF 309
	7)	Has anything out of the ordinary happened to you recently? Please explain		Dad died in Dec, grandmother died in Feb
	8)	Do you take medications to help you sleep? no	Please list:	
	9)	Have you taken any prescription or over the counter medications today? yes	Please list:	See list
	10)	Do any occurrences during sleep concern you? Wake tired		
	11)	Do you have any medical problems or sleep habits that the technician should be made aware of? no		
	12)	Did you consume any alcohol today? no		
	13)	Did you consume any caffeine today? yes		
	14)	Current vitals: Ht 5' 11" (1.803 m) Wt 286 lb (129.7 kg) BMI 39.89 kg/m ²		

Technician Summary

Current medications:

Current Outpatient Medications

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Technician Pretest Summary

Ms. Brown arrived on time for her sleep study. She is a very pleasant 42 year old. Her PMH includes: hypertension, rheumatoid arthritis, gastro paresis, GERD, anxiety, **depression**, fibromyalgia, attention deficit, back ache, chronic sinusitis, multinodular goiter and a previous **diagnosis** of OSA in 2013.

The patient had gastric sleeve surgery and quit using her CPAP after weight loss. She has been feeling more and more fatigued and thinks maybe she still needs the CPAP but no longer has the machine. She has regained some weight since then.

The patient has a history of severe daytime sleepiness and difficulty falling/staying asleep. She clenches her jaw when sleeping but does not wear a mouth guard. She was knocked unconscious in 1998 when she suffered a head injury.

The patient is aware of severe snoring. Her

Epworth Score is 4. The patient becomes drowsy when riding as a passenger for more than an hour or lying down to rest in

Date	Type	Specialty	Care Team	Description
	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 361 of 1113			the afternoon with 2 circumscribed permits. She typically does not use CPAP. She is unaware of any apnea or abnormal breathing. The patient typically awakens unrefreshed. She typically consumes 2 caffeinated beverages a day. The patient has not been using any <u>therapy</u> at home but when she used CPAP before she used a full face mask and feels she would like to use it again.
	14BPM			
	Time Epoch Stage Position SaO2 Modality			
	919pm			
	78 Wake Supine 97-99 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	no None No snoring 75-84 Cals/pt calcs done			
	LIGHTS OUT			
	CPAP 4cm cflex3			
	Additional comments:			
	Time Epoch Stage Position SaO2 Modality			
	930pm			
	100 Wake Right 98-99 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	no None No snoring 79-82			
	Additional comments: 948pm TECH IN to fix leg lead			
	Time Epoch Stage Position SaO2 Modality			
	1001pm			
	161 Wake Right 97 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	yes Couple possible hypopnea/ rera No snoring 87-90 TECH IN to change ear lead			
	Additional comments:			
	Time Epoch Stage Position SaO2 Modality			
	1030pm			
	220 3 Right 97-98 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	yes Couple possible hypopnea/ central No snoring 91-93			
	Additional comments:			
	Time Epoch Stage Position SaO2 Modality			
	11pm			
	280 3 Right 97 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	yes Possible central, hypopnea/ rera No snoring 94-97			
	Additional comments:			
	Time Epoch Stage Position SaO2 Modality			
	1130pm			
	340 3 Right 96-97 CPAP			
	Arousals Respiratory Events Snoring HR Comments			
	yes Possible hypopnea/ rera No snoring 91-98			

Time Epoch Stage Position SaO2 Modality
12am
400 2 Right 97-99 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/rera No snoring 79-87

Additional comments:

Time Epoch Stage Position SaO2 Modality
1230am
460 2 Right 97-98 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 80-85

Additional comments:

Time Epoch Stage Position SaO2 Modality
1am
520 2 Right 97-98 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 79-86

Additional comments:

Time Epoch Stage Position SaO2 Modality
130am
580 2 Right 97-98 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 78-83

Additional comments: 133am CPAP 6cm cflex3

Time Epoch Stage Position SaO2 Modality
2am
640 REM Supine 95-97 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 75-80

Additional comments:

Time Epoch Stage Position SaO2 Modality
230am
700 2 Supine 95 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 72-76

Additional comments: 256am CPAP 7cm cflex+1

Time Epoch Stage Position SaO2 Modality
3am

Arousals Respiratory Events Snoring HR Comments

yes Possible rera No snoring 73-77

Additional comments:

Time Epoch Stage Position SaO2 Modality
331am
821 REM Supine 96-100 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 74-79 CPAP 8cm clflex+2

Additional comments:

Time Epoch Stage Position SaO2 Modality
402am
884 REM Supine 92-95 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea/ rera No snoring 129- 150 CPAP 9cm clflex+3

Additional comments: 424am CPAP 10 cm clflex+3

Time Epoch Stage Position SaO2 Modality
430
940 REM Supine 93-95 CPAP

Arousals Respiratory Events Snoring HR Comments

yes Possible hypopnea No snoring 66-68

Additional comments: 451am CPAP 11cm clflex+3, 458am pt woke moving mask, LIGHTS ON, calcs/pt calcs done

Mask type: Amara View FFM
Mask size: Medium
Final CPAP setting: 11cm H2O
Supplemental **O2** Setting: None
Tolerance: Well
Humidifier: Heated
C-Flex: Plus 3
Chin Strap: None
Lights on: 458am
Lights off: 919pm
Bathroom visits: 0
Bed elevation: Flat
Number of pillows: 1

Post-Testing Questionnaire

How many hours/minutes do you think you slept? 8

How does this compare to the time you sleep at home? 6-8

Did you awaken during the night? yes

What caused you to awaken? mask

Was the mask you were wearing comfortable? yes

Were you able to tolerate the air pressure? yes

Did the CPAP machine make too much noise? no

Will you continue to try using the CPAP at home? yes

How was the room temperature during your test? perfect

How was the mattress/pillow during your test? comfortable

How was the noise level during your test? perfect

Were you able to get into your normal sleeping position? yes
If no, please describe why:

Were you treated in a professional and courteous manner by the technician? yes

Were all your questions and concerns answered? yes

Comments:

Author: Yvonne Tigue,RPSGT
Date and time completed: 4/29/2019 05:42

Electronically signed by Tigue, Yvonne at 04/29/2019 5:42 AM EDT

04/24/2019	Telephone	Jewell, Jan, RN	
04/22/2019	Ocular Visit	Galizia, Frank L, OD	Eyelid twitch (Primary Dx)

SAYRE
04/22/2019

Progress Notes - Galizia, Frank L, OD - 04/22/2019 1:30 PM EDT

Formatting of this note might be different from the original.

Patient Name: Jennifer Lyn Brown
MRN: 340616
Date of Birth: 10/26/1976

Assessment:

ICD-9-CM ICD-10-CM
1. Eyelid twitch 781.0 R25.3

Plan

Trial tonic water first, then consider referral for Botox with Dr. E McClintic next
Maintain planned follow up with me in Sept.

Author: Frank L Galizia, OD

04/18/2019	Electronically signed by Galizia, Frank L, OD at 04/22/2019 1:55 PM EDT	
	Emergency	Kniess, Carol Katherine, DO Emergency

Robert Packer Hospital
04/18/2019

ED Triage Notes - Smith, Jay, RN - 04/18/2019 2:15 PM EDT

PT to ER from FP clinic for HA and eye lid twitching. Pt state that she has had HA for 8 days and the twitching comes and goes.

ED Notes - Kelsall, Karen, RN - 04/18/2019 2:57 PM EDT

Agree with LPN assessment

Electronically signed by Kelsall, Karen, RN at 04/18/2019 2:57 PM EDT

ED Provider Notes - Kniess, Carol Katherine, DO - 04/18/2019 3:07 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/18/2019
 LOCATION: RPH EMERGENCY DEPARTMENT

History of Present Illness

Chief Complaint

Patient presents with
 • Headache

HPI

42 yo woman who presents to ED with typical headache that starts with neck pain and spreads to the occipital area and then the vertex of the head, and to the left frontal area above the left eye/orbit. No photophobia, neck stiffness, recent trauma. Symptoms have been intermittent for years and today's symptoms are typical. She was seen by Guthrie physician yesterday and had injections for pain at her neck, which she has had before. States this usually resolves neck and head pain, but just resolved neck pain, though headache still present. Usually helps with headache too. Not worst headache of life. Not sudden in onset. Started gradually and insidiously 8 days ago. Undergoing a lot of stress with caring for family members and working. No vision changes, photophobia, floaters, halos, blurry vision, nausea, vomiting, fever, chills, sweats, stiff neck, abdominal/chest/ back pain, leg pain or weakness, arm pain or weakness. No speech or swallowing problems. Had brief episodes of twitching in the area of her forehead above the left supraorbital ridge, lasting a few seconds, occurring a few times but are not present now. She states family practice wanted her to have a **CT scan**. Patient states she is walking and balancing ok. Feels she has been having memory issues over the last several months, becoming forgetful, but working and caring for family, and feels this has been fatiguing. No face pain, nasal congestion. Has been prescribed multiple different medication for her pain, and declines pain medication at this time. No dizziness or lightheadedness.

Patient Active Problem List

Diagnosis

- Plantar fascial fibromatosis
- Unspecified sinusitis (chronic)
- HTN (hypertension), benign
- GERD (Gastroesophagea I Reflux Disease)
- Rheumatoid arthritis (HCC)
- Hyperhidrosis disorder
- Obesity
- GAD (generalized **anxiety** disorder)
- Nontoxic multinodular goiter
- ADHD (attention deficit hyperactivity disorder)
- Severe obstructive sleep apnea
- Environmental allergies
- **Depression**
- Fibromyalgia
- Status post bariatric surgery
- Tremor of left hand
- Benign head tremor
- Crohn's disease (HCC)
- Multiple benign nevi
- Cherry angioma
- Sun-damaged skin

- Neuritis
- Drug eruption
- Rash
- Long term current use of immunosuppressiv e drug
- Vitamin D deficiency
- Vitamin B12 deficiency
- Therapeutic drug monitoring
- Myopia of both eyes
- Bilateral dry eyes
- Pain in joint, upper arm
- Impingement syndrome of left shoulder

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
 - **Depression** 1/20/2014
 - Endocrine problem
 - Epicondylitis elbow, medial 10/7/2008
 - Fatty liver
 - Fibromyalgia 8/20/2014
 - Fractures
 - Gastroparesis
 - irritable bowel syndrome
 - GERD (gastroesophagea l reflux disease) 10/7/2008
 - HTN (hypertension), benign 10/7/2008
 - Hypertension
 - Morbidly obese (HCC)
 - Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
 - EGD 2002
 - EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A; **362**
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGW-BJS Document 18 Filed 09/27/21 Page 36 of 112	Procedure: EGD COPY FILED IN LGSW BJS Surg: Simon, Michael, MD; Location: RPH MAIN OP			EXHIBIT NO. B2F PAGE: 39 OF 309
	• EGD N/A 6/11/2018			
	Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR			
	• EGD (GUTHRIE / NON GUTHRIE)			
	• LAPAROSCOPIC CHOLECYSTECTOMY 2013			
	with liver biopsy			
	• PR CLOSED RX TARSAL FX,EACH			
	• PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014			
	for obesity - Dr. Alley - RPH			
	• PR REMOVAL GALLBLADDER			
	• TONSILLECTOMY 11/26/07			
	Family History			
	Problem Relation Age of Onset			
	• Diabetes Mother			
	• Heart Mother			
	• Hypertension Mother			
	• Psychiatry Mother			
	Anxiety			
	• Arthritis Mother			
	• Heart Disease Mother			
	• Kidney Disease Mother			
	• Diabetes Father			
	• Hypertension Father			
	• Genetic Father			
	Marfan syndrome			
	• Heart Father			
	?Marfan's Syndrome			
	• Clotting Disorder Father			
	• Heart Disease Father			
	• Heart Paternal Uncle			
	Aortic Dissection, Marfan's Syndrome			
	• Heart Disease Paternal Uncle			
	• Diabetes Maternal Grandfather			
	• Thyroid Disease Maternal Grandfather			
	• Macular Degeneration Paternal Grandmother			
	• Psychiatry Maternal Aunt			
	ADHD			
	• Genetic Maternal Aunt			
	Marfan syndrome			
	• Psychiatry Other			
	ADHD			
	• Cancer Paternal Grandfather			
	• Glaucoma No family history			
	• Blindness No family history			
	• Other Eye Problems No family history			
	• Anesth Problems No family history			
	Social History			
	Tobacco Use			
	• Smoking status: Never Smoker			
	• Smokeless tobacco: Never Used			
	Substance Use Topics			
	• Alcohol use: No			
	Alcohol/week: 0.0 oz			
	• Drug use: No			
	Current Facility-Adminis tered Medications			
	Medication			
	• saline (OCEAN) nasal spray 0.65 %			
	Current Outpatient Medications			
	Medication Sig			
	• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.			

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-OF Document 18 Filed 08/27/23 Page 368 of 1112				EXHIBIT NO. B2F PAGE 40 OF 309
				<ul style="list-style-type: none"> calcium carbonate (CAL-DA) 1000 MG Oral Tablet Take 1 Tab by mouth DAILY. Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY. cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting). ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY. foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY. Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS. Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY. Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Review of Systems

Negative except per HPI above. All systems reviewed.

Physical Exam

Temp: 98 °F (36.7 °C) (04/18/19 1416)
Pulse: 88 (04/18/19 1416)
Resp: 18 (04/18/19 1416)
BP: 149/77 (04/18/19 1416)
SpO2: 96 % (04/18/19 1416)

Physical Exam

Constitutional No acute distress. Well appearing.

HEENT Normocephalic. Atraumatic. No temporal artery tenderness. PERRL. EOMI. Cornea clear. Sclera white. **Visual fields** full to confrontation. Moist mucous membranes

Neck Supple. Full, pain-free AROM. No meningismus.

Cardiovascular Regular rate. Regular rhythm. No UE/LE swelling or tenderness

Pulmonary Normal effort. No respiratory distress.

Abdominal Soft. No tenderness, distention, rebound, rigidity, or guarding.

Genitourinary Deferred

Back No focal tenderness

Musculoskeletal Moves all extremities spontaneously.

Neurological Level of Consciousness: Awake and alert. Not drowsy. Not lethargic. Not unresponsive.

Orientation: Oriented to person, place and time

Cranial Nerves: CNs II-XII are intact. No diplopia. No nystagmus.

Motor: Biceps, UE, EDMM is 5. No abnormal tone. No clonus. No tremor.
 Sensation: Gross LT/PP sensation of Face/UE/LE is intact.
 Speech: No dysarthria. No **aphasia**.
 Coordination: Finger to nose intact. Heel to shin intact.
Gait: steady without device, including standard **gait** and heel to toe **gait**. Normal unilateral balance .
 Skin Warm. Dry. No rash, petechiae, or purpura. No external signs of trauma.
 Psychiatric Cooperative.

ED Course
 Procedures

Critical Care Time: Critical Care < 30 minutes excluding billable procedures.

Patient Progress: stable.

Vitals:
 Temp: 98 °F (36.7 °C) (04/18/19 1416)
 Pulse: 88 (04/18/19 1416)
 Resp: 18 (04/18/19 1416)
 BP: 149/77 (04/18/19 1416)
 SpO2: 96 % (04/18/19 1416)

Assessment / Impression

1. Encounter for medical screening examination
2. Headache syndrome

Normal neuro exam
 Chronic headache syndrome
 Typical pain onset, location, character, quality
CT head requested by family practice
CT head shows no acute **findings**
 Do not suspect meningitis, temporal arteritis, subarachnoid hemorrhage, optic neuritis, or other acute emergent disorder
 Saw Dr. Attia yesterday for trigger point injection for chronic neck and head pain

Plan
 Discharge home with **PCP** follow up
 Continue working with pain management/Dr. Attia for trigger point **therapy** and pain management
 May benefit from neurology evaluation if headaches become intractable

Electronically signed by Kniess, Carol Katherine, DO at 04/18/2019 5:17 PM EDT
 Office Visit

Schutt, Lynn, NP

Intractable headache, unspecified
 chronicity pattern, unspecified
 headache type (Primary Dx);
 HTN (hypertension), benign

SAYRE

04/18/2019

Progress Notes - Schutt, Lynn, NP - 04/18/2019 1:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/18/2019

CHIEF COMPLAINT:
Chief Complaint
 Patient presents with

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI

Comes to office today with c/o sharp constant headache over left eye for past 8 days accompanied by intermittent eye twitching.

Denies any nausea or vomiting, blurred vision, numbness/tingling in any extremity at today's visit. She does c/o increasing memory issues.

She has taken tylenol, advil, exederin, flexeril and sudafed without relief.

Blood pressure is controlled in the office today 122/80. She is compliant with taking lisinopril. Denies any chest pain, shortness of breath, palpitations today.

She did have trigger point injection 4/17/2019 for chronic neck pain which is chronic. Thinking her neck pain was causing her headache. She states the neck pain is much better but the headache remains.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
 - **Depression** 1/20/2014
 - Endocrine problem
 - Epicondylitis elbow, medial 10/7/2008
 - Fatty liver
 - Fibromyalgia 8/20/2014
 - Fractures
 - Gastroparesis
 - irritable bowel syndrome
 - GERD (gastroesophageal reflux disease) 10/7/2008
 - HTN (hypertension), benign 10/7/2008
 - Hypertension
 - Morbidly obese (HCC)
 - Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

- Anxiety

 - Arthritis Mother
 - Heart Disease Mother
 - Kidney Disease Mother
 - Diabetes Father
 - Hypertension Father
 - Genetic Father
- Marfan syndrome

 - Heart Father
- ?Marfan's Syndrome

 - Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle
- Aortic Dissection, Marfan's Syndrome

 - Heart Disease Paternal Uncle
 - Diabetes Maternal Grandfather
 - Thyroid Disease Maternal Grandfather
 - Macular Degeneration Paternal Grandmother
 - Psychiatry Maternal Aunt
- ADHD

 - Genetic Maternal Aunt
- Marfan syndrome

 - Psychiatry Other
- ADHD

 - **Cancer** Paternal Grandfather
 - Glaucoma No family history
 - Blindness No family history
 - Other Eye Problems No family history
 - Anesth Problems No family history

Current Outpatient Medications

- Medication Sig

 - buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
 - calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
 - Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
 - cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
 - cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
 - EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
 - ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
 - fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
 - foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
 - Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
 - Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
 - Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
 - levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
 - lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
 - loratadine (CLARITIN,ALAUVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
 - methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
 - Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
 - ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
 - pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
 - Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
 - sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY.
 - Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
 - Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
 - venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
 - Years of education: Not on file
 - Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 oz

- Drug use: No

- Sexual activity: Yes

Partners: Male

Birth control/protecti on: Pill, Condom

Comment: OCPs

Lifestyle

- Physical activity:

Days per week: Not on file

Minutes per session: Not on file

- Stress: Not on file

Relationships

- Social connections:

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

- Intimate partner violence:

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Constitutional: Negative for chills and fever.
 HENT: Negative.
 Eyes: Negative.
 Respiratory: Negative for cough, shortness of breath and wheezing.
 Cardiovascular: Negative for chest pain, palpitations and leg swelling.
 Gastrointestinal : Negative for diarrhea, heartburn, nausea and vomiting.
 Genitourinary: Negative.
 Musculoskeletal: Positive for neck pain. Negative for falls.
 Neurological: Positive for dizziness and headaches. Negative for tingling, tremors, sensory change, speech change and weakness.

Objective

PHYSICAL EXAM:

VITALS: BP 122/80 (BP Location: Right arm, Patient Position: Sitting) | Pulse 84 | Temp 99.5 °F (37.5 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | SpO2 98% | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time.
 Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and lids are normal.
 Neck: Neck supple.
 Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
 Pulmonary/Chest: Effort normal and breath sounds normal. She has no wheezes. She has no rhonchi. She has no rales.
 Lymphadenopathy:
 Head (right side): No submental and no submandibular adenopathy present.
 Head (left side): No submental and no submandibular adenopathy present.
 She has no cervical adenopathy.
 Neurological: She is alert and oriented to person, place, and time. She has normal strength. She exhibits abnormal muscle tone (right grasp weaker than left). Coordination abnormal. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.
 Reflex Scores:
 Patellar reflexes are 1+ on the right side and 2+ on the left side.
 She did have some difficulty with rapid hand alternating movement, some difficulty performing the finger - nose - finger test.

Positive Romberg

When conducting eye movement testing patient became dizzy

Skin: Skin is warm, dry and intact.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Intractable headache, unspecified chronicity pattern, unspecified headache type 784.0 R51
2. HTN (hypertension), benign 401.1 I10

Plan

1. Due to neuro deficits, intractable headache, dizziness patient was suggested to go to the ED. She stated understanding and stated she was going directly there after this appointment.

T/c to ED to make aware of patient arrival.

Patient aware and agreeable with plan of care.

Author: Lynn Schutt, NP 4/18/2019 14:09

Electronically signed by Schutt, Lynn, NP at 04/18/2019 2:20 PM EDT

Nursing Note - Myers, Thomas, LPN - 04/18/2019 1:00 PM EDT

Formatting of this note might be different from the original.

Chief Complaint

Patient presents with

- Headache

Author: Thomas Myers, LPN 4/18/2019 13:03

Electronically signed by Myers, Thomas, LPN at 04/18/2019 1:15 PM EDT

Telephone

Myers, Thomas, LPN

Care Team Huddle

SAYRE
04/18/2019

Telephone Encounter - Myers, Thomas, LPN - 04/18/2019 10:39 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 4/18/2019

Patient was reviewed during care team huddle.

The patient has the following care gaps:

Cancer Screening Care Gaps
Patient has no health maintenance due at this time

Wellness General Care Gaps

LIPID DISORDER SCREENING Overdue 3/12/2019

Adult Immunization Care Gaps

PNEUMOCOCCAL 0-64 YRS Overdue 7/8/2017

PAST **PCP**-RELATED VISIT INFORMATION:

Last encounter date in **PCP** primary department: 04/17/2019

Last Visit with **PCP**:
Visit Information
Date & Time
1/31/2019 1:40 PM Provider
Gillan, Michael F, DO Department
Sayre Family Practice Encounter #
74195016

BP Readings from Last 1 Encounters:
04/17/19 130/86

Date	Type	Specialty	Care Team	Description
04/17/2019	Office Visit	Attia, Maximos, MD	Electronically signed by Myers, Thomas, LPN at 04/18/2019 10:40 AM EDT	Muscle pain, cervical (Primary Dx)

EXHIBIT NO. B2F
PAGE: 47 OF 309

SAYRE
04/17/2019

Progress Notes - Attia, Maximos, MD - 04/17/2019 12:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 4/17/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Neck Pain

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI

The history is provided by the patient. This is a recurrent problem. The current episode started several years ago (since 1998). The problem occurs intermittently. The problem has been waxing and waning. The pain is associated with falling. There has been no fever. The pain is present in the occipital region and both sides of the neck. The quality of the pain is described as stabbing and burning. The pain is at a severity of 5/10. The pain is moderate. The symptoms are aggravated by bending. She has tried heat for the symptoms. The pain does not radiate.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea I reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere

- Physiologic ovarian cysts 10/4/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS.

Use weekly for methotrexate

- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 377 of 1112				EXHIBIT NO. B2F PAGE: 49 OF 309
	with methotrexate weekly			
				<ul style="list-style-type: none"> • levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. • loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. • methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. • Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. • pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. • Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn • sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY. • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY. • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications
Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
 - Years of education: Not on file
 - Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 oz

- Drug use: No

- Sexual activity: Yes

Partners: Male

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

- Physical activity:

Days per week: Not on file

Minutes per session: Not on file

- Stress: Not on file

Relationships

- Social connections:

Talks on phone: Not on file

Gets together with friends: Not on file
 Attends religious service: Not on file
 Active member of club or organization: Not on file
 Attends meetings of clubs or organizations: Not on file
 Relationship status: Not on file
 • Intimate partner violence:
 Fear of current or ex partner: Not on file
 Emotionally abused: Not on file
 Physically abused: Not on file
 Forced sexual activity: Not on file
 Other Topics Concern
 • Not on file
 Social History Narrative
 August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

ROS
 Constitutional: Negative for chills and fever.
 Skin: Negative for itching and rash.

Objective

PHYSICAL EXAM:
 VITALS: BP 130/86 (BP Location: Right arm, Patient Position: Sitting) | Pulse 86 | Temp 99.6 °F (37.6 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | SpO2 98% | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².
 Physical Exam
 Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.
 HENT:
 Head: Normocephalic and atraumatic.
 Right Ear: External ear normal.
 Left Ear: External ear normal.
 Nose: Nose normal.
 Eyes: Conjunctivae are normal. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
 Cardiovascular: Normal rate and regular rhythm.
 Pulmonary/Chest: Effort normal. No respiratory distress.
 Musculoskeletal: She exhibits tenderness. She exhibits no edema.
 Tender spots over both sides of neck.
 Neurological: She is alert and oriented to person, place, and time.
 Skin: Skin is warm and dry. She is not diaphoretic.
 Psychiatric: Affect and judgment normal.
 Vitals reviewed.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM
 1. Muscle pain, cervical 723.1 M54.2 INJECTION TRIGGER POINTS 3 OR MORE MUSCLES

Plan
 Trigger point injection procedure note :
 The procedure risks, hazards and alternatives were discussed with the patient and a consent was obtained. The area over the myofascial spasm were prepped with alcohol utilizing sterile technique. After isolating it between two palpating fingertips a 25-gauge needle was placed in the center of the myofascial spasms and a negative aspiration was performed. Then a total of 10 cc of Lidocaine 1% was injected into the trigger points. The patient tolerated the procedure well without any apparent difficulties or complications. Patient was feeling relief by the time the block had set.
 Injection was made on the both sides of neck.

Author: Maximos Attia, MD 4/17/2019 14:14
 Electronically signed by Attia, Maximos, MD at 04/17/2019 2:14 PM EDT
 Nursing Note - Myers, Thomas, LPN - 04/17/2019 12:00 PM EDT

Chief Complaint

Patient presents with

- Injection

Neck

Author: Thomas Myers, LPN 4/17/2019 12:09

Electronically signed by Myers, Thomas, LPN at 04/17/2019 12:41 PM EDT

04/16/2019	Telephone	Rollison, Michelle	Other
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SAYRE
04/16/2019

Telephone Encounter - Rollison, Michelle - 04/16/2019 7:40 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/16/2019

Pt normally sees Dr. Attia for trigger point injections in her neck. Pt states he fits her in as needed. She calls stating she is in agony with her neck and is wondering if there is anyway she can be fit in to be seen to have this done as soon as possible. Please advise the pt at x2487
 Thank you

Author: Michelle Rollison 4/16/2019 07:40

Electronically signed by Rollison, Michelle at 04/16/2019 7:41 AM EDT

04/12/2019	Refill	Gillan, Michael F, DO	HTN (hypertension), benign; <u>Depression</u> , unspecified <u>depression</u> type; GAD (generalized <u>anxiety</u> disorder)
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SAYRE
04/12/2019

Telephone Encounter - Brown, Miranda, LPN - 04/12/2019 1:56 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/12/2019

Requested Prescriptions

Pending Prescriptions Disp Refills

- pantoprazole (PROTONIX) 40 MG Oral Tab EC 90 Tab 3
 Sig: Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab 90 Tab 3
 Sig: Take 1 Tab by mouth DAILY.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR 90 Tab 3
 Sig: Take 1 Tab by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR 90 Cap 0
 Sig: Take 1 Cap by mouth DAILY.

Author: Miranda Brown, LPN 4/12/2019 13:56

Electronically signed by Brown, Miranda, LPN at 04/12/2019 1:58 PM EDT

Telephone Encounter - Gillan, Michael F, DO - 04/15/2019 7:14 AM EDT

Formatting of this note might be different from the original.

Name: Jennifer Lyn Brown

DOB: 10/26/1976

MRN: 340616

Date of Service: 4/12/2019

Lab **Results**

Component Value Date

NA 139 01/17/2019

K 4.2 01/17/2019

CL 104 01/17/2019

CO2 27 01/17/2019

GLUCOSE 101 (H) 01/17/2019

BUN 14 01/17/2019

CREATININE 1.0 01/17/2019

CALCIUM 8.9 01/17/2019

EGFR >60 01/17/2019

Medications refilled after chart review.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 04/15/2019 7:17 AM EDT

04/12/2019 Refill Georgetson, Michael J, MD FACG

SAYRE

04/12/2019

Telephone Encounter - Hinds, Jennifer, LPN - 04/19/2019 1:22 PM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Signed Prescriptions Disp Refills

• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc 12 Each 0

Sig: Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days

Authorizing Provider: GEORGETSON, MICHAEL

Escribed to Pharmacy.

Jennifer Hinds, LPN

Electronically signed by Hinds, Jennifer, LPN at 04/19/2019 1:22 PM EDT

03/29/2019 Orders Only Gillan, Michael F, DO

03/29/2019 Telephone Gillan, Michael F, DO

SAYRE

03/29/2019

376

Name: Jennifer Lyn Brown
 DOB: 10/26/1976
 MRN: 340616
 Date of Service: 3/29/2019

Sleep study positive, CPAP titration study recommended. If patient is agreeable I will order.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 03/29/2019 3:35 PM EDT

Telephone Encounter - Prough, Shannon, LPN - 04/01/2019 8:47 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/1/2019

Left a message for patient to call back.
 In regard to Dr.Gillan's message.

Author: Shannon Prough, LPN 4/1/2019 08:47

Electronically signed by Prough, Shannon, LPN at 04/01/2019 8:48 AM EDT

Telephone Encounter - Prough, Shannon, LPN - 04/03/2019 8:37 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 4/3/2019

Patient notified and is agreeable.

Author: Shannon Prough, LPN 4/3/2019 08:37

Electronically signed by Prough, Shannon, LPN at 04/03/2019 8:38 AM EDT

Telephone Encounter - Gillan, Michael F, DO - 04/03/2019 8:41 AM EDT

Name: Jennifer Lyn Brown
 DOB: 10/26/1976
 MRN: 340616
 Date of Service: 3/29/2019

Ordered.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 04/03/2019 8:41 AM EDT

03/22/2019	Hospital Encounter	Outpatient
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Robert Packer Hospital 03/22/2019 Progress Notes - Merrill, Joan, RRT - 03/22/2019 11:59 PM EDT
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Formatting of this note might be different from the original.

Guthrie Sleep Disorders Center
 RPH Sleep Lab

Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 382 of 1112
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4639

EXHIBIT NO. B2F
PAGE: 54 OF 309

Patient: Jennifer Lyn Brown
 MRN: 340616
 Date of birth: 10/26/1976
 Study Type: NPSG
 Date of test: 3/22/2019
 Technician: Joan Merrill, RRT
 Room #: 1
 Acq #: 01001288

Pre-Testing Questionnaire

- 1) What time did you fall asleep last night? 10 pm
- 2) What time did you wake up this morning? 540 am
- 3) Was this a typical night's sleep for you? yes
 If no, please explain:
- 4) Approximately how many hours did you sleep...
 Last night 6.5
 Two nights ago 7
 Three nights ago 7
- 5) How many naps did you have today? none
 How long?
- 6) How tired/sleepy are you now? (Wide awake = 1, Can't keep my eyes open = 10) 6
- 7) Has anything out of the ordinary happened to you recently? yes Please explain Lost my dad 12/4/2018 and my grandma 2/7/19-under a lot of stress
- 8) Do you take medications to help you sleep? no Please list:
- 9) Have you taken any prescription or over the counter medications today? yes Please list: See below
- 10) Do any occurrences during sleep concern you? Just wake up tired.
- 11) Do you have any medical problems or sleep habits that the technician should be made aware? none
- 12) Did you consume any alcohol today? no
- 13) Did you consume any caffeine today? yes
- 14) Current vitals: Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m²

Technician Summary

Current medications:

Current Outpatient Medications

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 383 of 1112				
	NEEDED	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 383 of 1112		EXHIBIT NO. B2F PAGE: 55 OF 309
				<ul style="list-style-type: none"> • pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. • Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn • sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY. • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Technician Pretest Summary

Ms. Brown arrived on time for her sleep study. She is a very pleasant 42 year old. Her PMH includes:hyperte nsion,rheumatoid arthritis,gastro paresis,GERD,anx iety,**depression**, fibromyalgia,att ention deficit,back ache,chronic sinusitis,mutino dular goiter and a previous **diagnosis** of OSA in 2013.

The patient had gastric sleeve surgery and quit using her CPAP after weight loss. She has been feeling more and more fatigued and thinks maybe she still needs the CPAP but no longer has the machine.She has regained some weight since then.

The patient has a history of severe daytime sleepiness and difficulty falling/staying asleep. She clenches her jaw when sleeping. She was knocked unconscious in 1998 when she suffered a head injury.

The patient is aware of severe snoring. Her

Epworth Score is 4. The patient becomes drowsy when riding as a passenger for more than an hour or lying down to rest in the afternoon when circumstances permit. She typically does not nap. She is unaware of any apnea/abnormal breathing.

The patient typically awakens unrefreshed. She typically consumes 2 caffeinated beverages a day. The patient has not been using any **therapy** at home. Sleep apnea and CPAP discussed with the patient.She was setup according to policy and procedure.

Time Epoch Stage Position SaO2 Modality

2236

112 Wake Supine 97 N/A

Arousals Respiratory Events Snoring HR Comments

Respiratory rate 18 86 Calibrations begun

Additional comments: 2234 LIGHTS OUT

Time Epoch Stage Position SaO2 Modality

2306

172 Wake/1/2 Supine/right 96 N/A

Arousals Respiratory Events Snoring HR Comments

yes None No snoring 92 Tachycardia

Additional comments:

Time Epoch Stage Position SaO2 Modality

2336

232 2/3 Right 96 N/A

Arousals Respiratory Events Snoring HR Comments

yes Possible RERAS Moderate snoring 101 Tachycardia

Additional comments:

Time Epoch Stage Position SaO2 Modality

0006

292 3/2 Right 96 N/A

yes None Occasional moderate snoring 97 Tachycardia

Additional comments:

Time Epoch Stage Position SaO2 Modality
0036
352 2/3/2/3 Right 96 N/A

Arousals Respiratory Events Snoring HR Comments

yes Hypopneas Occasional moderate snoring 100 Tachycardia

Additional comments:

Time Epoch Stage Position SaO2 Modality
0106
412 3/2 Right 96 N/A

Arousals Respiratory Events Snoring HR Comments

yes RERAs Light snoring 94 Tachycardia

Additional comments:

Time Epoch Stage Position SaO2 Modality
0136
472 2 Right/supine 91 N/A

Arousals Respiratory Events Snoring HR Comments

yes Hypopneas and RERAs Light snoring 88

Additional comments:

Time Epoch Stage Position SaO2 Modality
0206
532 2/3 Supine 90 N/A

Arousals Respiratory Events Snoring HR Comments

yes Hypopneas and RERAs Moderate to heavy snoring 89

Additional comments:

Time Epoch Stage Position SaO2 Modality
0236
592 3/2 Supine 95 N/A

Arousals Respiratory Events Snoring HR Comments

yes Hypopneas and RERAs Occasional heavy snoring 84

Additional comments:

Time Epoch Stage Position SaO2 Modality
0306
652 2/REM Supine 93 N/A

Arousals Respiratory Events Snoring HR Comments

yes Hypopneas, RERAs and Mixed apnea Occasional heavy snoring 77

Additional comments:

Time Epoch Stage Position SaO2 Modality
0336
712 2 Supine/right 96 N/A

Arousals Respiratory Events Snoring HR Comments

yes RERAs Moderate to heavy snoring 80

Additional comments:

Time Epoch Stage Position SaO2 Modality
0406
772 2 Right 96 N/A

Arousals Respiratory Events Snoring HR Comments

few None Light snoring 84 Leg movements

Additional comments:

Time Epoch Stage Position SaO2 Modality
0436
832 2/REM Right 98 N/A

Arousals Respiratory Events Snoring HR Comments

yes RERAs Light snoring 81 Leg movements

Additional comments:

Time Epoch Stage Position SaO2 Modality
0506
892 2 Right 95 N/A

Arousals Respiratory Events Snoring HR Comments

few Couple RERAs Moderate snoring 79

Additional comments: 0529 LIGHTS ON. Calibrations

Supplemental **O2** Setting: No oxygen used
Tolerance: Very well
Humidifier: heated
C-Flex:
Chin Strap:
Lights on: 0529
Lights off: 2244
Bathroom visits: 0
Bed elevation: Flat
Number of pillows: 1

Post-Testing Questionnaire

- 1) How long did it take you to fall asleep last night? hrs 30 min
- 2) How many times did you wake up last night? 2
- 3) How tired/sleepy are you now? (can't keep my eyes open = 1, wide awake = 5) 4
- 4) Was the bed comfortable? (not at all = 1, very = 5) 5
- 5) Was the temperature comfortable? (not at all = 1, very = 5) 5
- 6) Was the noise level comfortable? (noisy = 1, quiet = 5) 5
- 7) Was our staff attentive to your needs? (not at all = 1, very = 5) 5
- 8) How long do you think you slept last night? hrs min
- 9) Did you have difficulty falling asleep last night? yes If so, why?: Different place
- 10) Did you dream last night? yes
- 11) Did you have any trouble breathing last night? no

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGT Document 1-3 Filed 08/27/23 Page 386 of 1112				
	12) Do you remember moving in your sleep? No			EXHIBIT NO. B2F PAGE: 58 OF 309
	13) Do any of the following describe how you feel this morning? Still sleepy			
	14) How did the quality of sleep last night compare to your usual sleep at home? Better			
	15) If you could use one word to describe your experience, what would it be? restful			
	Please share with us how we could improve your visit. N/A			
	Comments: Joan is an excellent technician. Very patient centered.			

Author: Joan Merrill, RRT

Date and time completed: 3/23/2019 06:29

Electronically signed by Merrill, Joan, RRT at 03/23/2019 6:30 AM EDT

Refill

Jewell, Jan, RN

SAYRE

03/13/2019

Telephone Encounter - Jewell, Jan, RN - 03/13/2019 9:58 AM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Pending Prescriptions Disp Refills

• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 100 Each 0
Sig: 1 Each by Does not apply route EVERY 7 DAYS.

Electronically signed by Jewell, Jan, RN at 03/13/2019 10:00 AM EDT

Telephone Encounter - Jewell, Jan, RN - 03/14/2019 7:55 AM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Signed Prescriptions Disp Refills

• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 100 Each 0
Sig: 1 Each by Does not apply route EVERY 7 DAYS.

Authorizing Provider: FREEMAN, JAMES G

E-script done by provider..

Electronically signed by Jewell, Jan, RN at 03/14/2019 7:55 AM EDT

Gastro

Nurse/clinical

support

Crohn's disease with
complication, unspecified
gastrointestinal tract location
(HCC) (Primary Dx)

SAYRE

03/11/2019

Nursing Note - Shaw, Beth, RN - 03/11/2019 10:00 AM EDT

Patient originally scheduled today for repeat Stelara injection teaching with significant other. Since significant other unable to come in for patient's appointment, Stelara injection given to patient by GI nurse. Patient is unable to give herself injections. Stelara injection given to patient's left upper outer/back of arm at a 45% angle. Site clean, dry and intact.

Patient will schedule next injection in 8 weeks (April 6, 2019), hopefully with significant other, for injection teaching.

Electronically signed by Shaw, Beth, RN at 03/11/2019 11:04 AM EDT

Telephone

Yanchuk, Ashley, ST

SAYRE

03/04/2019

Telephone Encounter - Yanchuk, Ashley, ST - 03/04/2019 9:48 AM EST

SAYRE
03/01/2019

Progress Notes - Watson, Brittany, PA - 03/01/2019 8:00 AM EST

Formatting of this note might be different from the original.

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 3/1/2019

Chief Complaint

Patient presents with

- Shoulder Pain

New left shoulder pain x1 year.

HPI: Jennifer Lyn Brown is a 42-y.o. female who presents for evaluation of left shoulder pain. She is right hand dominant. Patient states that she has had pain in the left shoulder for a year. It began when she was lifting furniture and she felt a snap in her shoulder. She notes that her pain is constant and is superior and radiates down the arm. She admits to increased pain with lifting, laying down, reaching overhead, reaching behind her, getting dressed, and reaching forward. Her pain has worsened since onset. She admits that she has tried rest, ice, heat, physical **therapy**, and cortisone injections in the shoulder which do not help. She cannot take NSAIDs due to underlying GI issues. Patient saw Dr. Auerbach for this issue and was signed up for surgery but she would like to see Dr. Choi for this issue instead. She denies paraesthesias.

PAST MEDICAL HISTORY: has a past medical history of Anal fissure (1/2013), **Anxiety**, Attention deficit, Back ache (3/18/2014), Calcaneal spur (6/30/2008), Cherry angioma (8/9/2016), Cholecystitis, CHRONIC SINUSITIS NOS (5/23/2005), Crohn disease (HCC), **Depression** (1/20/2014), Endocrine problem, Epicondylitis elbow, medial (10/7/2008), Fatty liver, Fibromyalgia (8/20/2014), Fractures, Gastroparesis, GERD (gastroesophageal reflux disease) (10/7/2008), HTN (hypertension), benign (10/7/2008), Hypertension, Morbidly obese (HCC), Multinodular goiter, Nontoxic multinodular goiter (1/18/2011), Obesity, Persistent mental disorders due to conditions classified elsewhere, Physiological ovarian cysts (10/7/2008), PLANTAR FIBROMATOSIS (9/9/2004), Premenopausal patient, Rheumatoid arthritis(714.0) (12/12/2008), Severe obstructive sleep apnea (6/10/2013), Sleep apnea, Thyroid nodule (6/3/2010), and Wrist fracture.

PAST SURGICAL HISTORY: has a past surgical history that includes tonsillectomy (11/26/07); egd (2002); egd (guthrie / non guthrie); laparoscopic cholecystectomy (2013); egd (N/A, 8/13/2014); pr lap, gast restrict proc, longitudinal gastrectomy (12/10/2014); pr removal gallbladder; pr closed rx tarsal fx,each; colonoscopy (N/A, 6/24/2016); egd (N/A, 6/24/2016); colonoscopy diagnostic; colonoscopy (N/A, 6/2/2017); egd (N/A, 6/2/2017); colonoscopy (N/A, 6/11/2018); and egd (N/A, 6/11/2018).

MEDICATIONS:

Current Outpatient Medications:

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses., Disp: 12 mL, Rfl: 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap, Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks., Disp: 8 Cap, Rfl: 1
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 5
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate, Disp: 100 Each, Rfl: 1

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGS Document 18 Filed 08/27/23 Page 388 of 1112				EXHIBIT NO. B2F PAGE: 60 OF 309
				<ul style="list-style-type: none"> • Insulin Syringe/Needle, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0 • with methotrexate weekly, Disp: 100 Each, Rfl: 0 • levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0 • methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution, Inject 1 mL beneath the skin EVERY SATURDAY., Disp: 12 mL, Rfl: 1 • Nitroglycerin 0.4 % Rectal Ointment, Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator., Disp: 1 Tube, Rfl: 0 • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1 • pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3 • sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC, Take 2 Tabs by mouth TWICE DAILY., Disp: 120 Tab, Rfl: 3 • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0 • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks., Disp: 1 Syringe, Rfl: 5 • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS, Disp: 90 Cap, Rfl: 0 • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 0

Current Facility-Adminis tered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

ALLERGIES: She is allergic to bee stings [bee sting]; remicade [infliximab]; and tape: silk or adhesive.

SOCIAL HISTORY: She reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

FAMILY HISTORY: She family history includes Arthritis in her mother; **Cancer** in her paternal grandfather; Clotting Disorder in her father; Diabetes in her father, maternal grandfather, and mother; Genetic in her father and maternal aunt; Heart in her father, mother, and paternal uncle; Heart Disease in her father, mother, and paternal uncle; Hypertension in her father and mother; Kidney Disease in her mother; Macular Degeneration in her paternal grandmother; Psychiatry in her maternal aunt, mother, and other; Thyroid Disease in her maternal grandfather.

ROS: See HPI otherwise all other ROS are negative at this time

Exam:

Resp 20 | Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m²

Shoulder Exam

General: pleasant, alert and oriented x 3, no apparent distress

Skin: warm, dry and intact

Muscle Bulk: symmetrical, aligned, no masses or deformity

Crepitus: Negative

Neurovascular

Sensation: axillary/median/ ulnar/radial nerve sensate to light touch

Strength: biceps, triceps, wrist extension, wrist flexion, interossei 5/5

Vascular: 2+ radial pulse

C-spine: negative

Range of motion

Forward elevation: 180

Internal rotation: L2

External rotation: 45

Rotation 90 Abduction: 0-70

Subscapularis

Belly Press: Negative

Lift Off: Negative

Bear Hug: Negative

Supraspinatus
Supraspinatus strength testing: 5/5

Infraspinatus/Teres Minor
External rotation strength: 5/5
Hornblower: Negative

Impingement
Cross Abduction: Positive
Acromioclavicular joint: Positive
Neer: Positive
Hawkins: Positive

Biceps Tendon Test
Yergson: Negative
Speeds: Negative

Superior Labrum Test
O'Brien Test: Negative
Anterior slide test: Negative

Instability
Anterior 0
Posterior 0
Multidirectional 0

Scapula: Negative
SC joint: Negative
Clavicle: Negative

X-rays: films visualized of left shoulder demonstrates mild AC joint arthritis.
MRI - Negative for overt rotator cuff tear, AC joint arthritis. Images reviewed visualized with patient.

ASSESSMENT:
ICD-9-CM ICD-10-CM
1. Impingement syndrome of left shoulder 726.2 M75.42 CASE REQUEST OPERATING ROOM

PLAN:

I discussed the **findings** with the patient. She has failed conservative including cortisone injections and physical **therapy**. We discussed left shoulder arthroscopic subacromial decompression, distal clavicle excision. The risks to surgery include bleeding, infection, nerve damage, wound healing problems, shoulder stiffness, possibility of revision surgery down the road, RSD, blood clots, lung clots, death, and anesthetic related complications. The patient understands the risks and wishes to proceed with surgery. I will get the patient scheduled. Patient will have a meet and greet with Dr. Choi prior to the procedure. She may contact our office with any questions or concerns.

Author: Brittany Watson, PA 3/1/2019 08:49

Electronically signed by Watson, Brittany, PA at 03/01/2019 8:49 AM EST

Nursing Note - Westbrook, Heather, LPN - 03/01/2019 8:00 AM EST

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 3/1/2019

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.

Date	Type	Specialty	Care Team	Description
Case 8:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 390 of 1112				
	EXHIBIT NO. B2F PAGE: 62 OF 309			
	INTEGUMENTARY: Negative. HEMATOLOGIC/LYMPHATIC: negative. MUSCULOSKELETAL: Negative except Left shoulder pain. NEUROLOGICAL: negative. BEHAVIORAL/PSYCH : negative. ENDOCRINE: Negative. ALLERGIC/IMMUNOLOGIC: Negative.			
	Body mass index is 39.89 kg/m².			
	AUTHOR: Heather Westbrook, LPN 3/1/2019 08:15			
02/27/2019	Office Visit	Electronically signed by Westbrook, Heather, LPN at 03/01/2019 8:18 AM EST Freeman, James, MD		Rheumatoid arthritis, involving unspecified site, unspecified rheumatoid factor presence (HCC) (Primary Dx); Inflammatory arthritis

SAYRE
02/27/2019

Progress Notes - Regmi, Asish, MD - 02/27/2019 2:20 PM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 2/27/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female is here for her follow up visit.

HPI

Jennifer Lyn Brown is a 42-y.o. Female With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira, now changed to Ustekinumab by GI, methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Patient has also been following GI for crohn's disease.

Patient said that after she was started on Ustekinumab her swelling has gone better she still has pain.

She also had swelling of her wrist 2 weeks back

She has pain in her wrist and knuckles. The pain is usually worst in the morning and she also has stiffness with it, and slowly gets better after day progress.

She is also complaining of fatigue.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- **CT** 2005
- Crohn disease (HCC)

- Depression 10/7/2008
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father

?Marfan's Syndrome

- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LOF Document 18 Filed 08/27/23 Page 392 of 1112				EXHIBIT NO. B2F PAGE 64 OF 309
				<ul style="list-style-type: none"> calcium carbonate (CAL-MAX) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY. Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY. cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting). ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY. foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY. Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY. lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY. loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY. Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator. ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications
Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 oz

• Drug use:

• Sexual activity: Yes

Partners: Male

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

• Physical activity:

Days per week: Not on file

Minutes per session: Not on file

• Stress: Not on file

Relationships

• Social connections:

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

• Intimate partner violence:

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative for chills, fever and weight loss.

HENT: Negative for ear pain, hearing loss and tinnitus.

Eyes: Negative for blurred vision, double vision and photophobia.

Respiratory: Negative for cough, hemoptysis and sputum production.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal : Negative for heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency and urgency.

Musculoskeletal: Positive for joint pain.

Skin: Negative for itching and rash.

Neurological: Negative for dizziness, tingling and headaches.

Endo/Heme/Allerg ies: Negative for environmental allergies. Does not bruise/bleed easily.

Objective

PHYSICAL EXAM:

VITALS: BP 120/88 | Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate and regular rhythm. Exam reveals no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema.

Tenderness in wrist joint.

Tender point in shoulder and hip as well

Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit. Coordination normal

Skin: Skin is warm and dry.

ASSESSMENT / IMPRESSION:

Plan

Rheumatoid arthritis:
Recently changed from humeria to Ustekinumab by GI.
Still having some pain.
Completed her steroids.
Start on sulfasalazine 1000 mg BID: Risks and benefits detailed.
Continue methotrexate

Fibromyalgia:
She has tender points in her body.
Most likely has some component of fibromyalgia.
Flexeril did not work.

Follow up in 3 months

D/W Dr Freeman and agreed upon.

Author: Asish Regmi, MD 2/27/2019 14:58

Electronically signed by Freeman, James, MD at 03/06/2019 3:09 PM EST
02/07/2019 Hospital Encounter

Robert Packer
Hospital
02/07/2019

02/07/2019	Office Visit	Tompkins, Nancy, NP	Outpatient Lateral epicondylitis of right elbow (Primary Dx)
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SAYRE
02/07/2019

Progress Notes - Tompkins, Nancy, NP - 02/07/2019 3:30 PM EST

Formatting of this note might be different from the original.

HAND SURGERY FOLLOW UP NOTE

Name: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of service: 2/7/2019

Chief Complaint

Patient presents with

- New Patient

New to you. Right elbow pain since for about a year. Previously saw Mike Gorsline. Has gone to occupational **therapy** & has had an **EMG** done. States pain is now going down into her wrist. States mild numbness & tingling in the fingers

Jennifer Lyn Brown is here today for follow up right elbow pain. According to the patient her elbow has ached for almost a year. She states pain on outside of elbow. She has tried NSAIDs and occupational **therapy** without relief.

ROS: Nursing Notes:
Cecee, Nicole, LPN 2/7/2019 3:45 PM Addendum
NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 2/7/2019

CONSTITUTIONAL: negative.
 HEENT: negative.
 EYES: negative
 RESPIRATORY: negative.
 CARDIOVASCULAR: negative.
 GASTROINTESTINAL : negative.
 GENITOURINARY: negative.
 INTEGUMENT/BREAS T: negative.
 HEMATOLOGIC/LYMP HATIC: negative.
 MUSCULOSKELETAL: negative except New to you. Right elbow pain for about a year. Previously saw Mike Gorsline. Has gone to occupational **therapy**
 NEUROLOGICAL: negative.
 BEHAVIORAL/PSYCH : negative.
 ENDOCRINE: negative.
 ALLERGIC/IMMUNOL OGIC: Negative.

Body mass index is 40.31 kg/m².

AUTHOR: Nicole Cecee, LPN 2/7/2019 15:35

I reviewed the above and have made changes as appropriate.

Vitals: Ht 5' 11" (1.803 m) Wt 289 lb (131.1 kg) BMI 40.31 kg/m2
 On exam, she is alert and oriented, in no acute distress. Skin clean dry and intact. No swelling. Point tenderness lateral epicondyle. Full range of motion. Good sensation. Brisk cap refill.

Xray of elbow reviewed and no bony abnormality noted

Assessment:

ICD-9-CM ICD-10-CM

- 1. Lateral epicondylitis of right elbow 726.32 M77.11

Plan:

We discussed the general approach to lateral epicondylitis and the basic pathoanatomy. Usual causes include activities with repetitive gripping and grasping, as well as loading. Treatments are aimed at symptom control, with surgery reserved only for refractory cases. This is almost always a self-limiting condition that burns itself out with time. The time frame is generally up to a year but may be longer. Cortisone injections can help decrease the symptoms, though there is evidence that cortisone may prolong time to final resolution. Consider hand **therapy** evaluation for home exercise program and activity modification. A counterforce brace can be helpful in some patients.

Follow up: open

Nancy Tompkins, NP
 Hand Surgery
 2/7/2019

Electronically signed by Tompkins, Nancy, NP at 02/08/2019 1:16 PM EST

Nursing Note - Cecce, Nicole, LPN - 02/07/2019 3:30 PM EST

NAME: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 2/7/2019

CONSTITUTIONAL: negative.
 HEENT: negative.
 EYES: negative
 RESPIRATORY: negative.
 CARDIOVASCULAR: negative.
 GASTROINTESTINAL : negative.
 GENITOURINARY: negative.
 INTEGUMENT/BREAS T: negative.
 HEMATOLOGIC/LYMP HATIC: negative.
 MUSCULOSKELETAL: negative except New to you. Right elbow pain for about a year. Previously saw Mike Gorsline. Has

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gone to occupational therapy.
 NEUROLOGICAL: negative.
 BEHAVIORAL/PSYCH : negative.
 ENDOCRINE: negative.
 ALLERGIC/IMMUNOLOGIC: Negative.

Body mass index is 40.31 kg/m².

AUTHOR: Nicole Cecee, LPN 2/7/2019 15:35

Electronically signed by Cecce, Nicole, LPN at 02/07/2019 3:45 PM EST

02/07/2019	Orders Only	Conklin, Debra, LPN		
02/06/2019	Telephone	Rollison, Michelle		Other

SAYRE
02/06/2019

Telephone Encounter - Rollison, Michelle - 02/06/2019 2:10 PM EST

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 2/6/2019

The referral was put in for genetic testing, it needs to be for hematology/oncology.
 Karissa from hematology calls down to have this corrected.
 Thank you

Author: Michelle Rollison 2/6/2019 14:10

Electronically signed by Rollison, Michelle at 02/06/2019 2:12 PM EST

Telephone Encounter - Gillan, Michael F, DO - 02/06/2019 2:21 PM EST

Name: Jennifer Lyn Brown
 DOB: 10/26/1976
 MRN: 340616
 Date of Service: 2/6/2019

Done.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 02/06/2019 2:21 PM EST

02/05/2019	Telephone	Jewell, Jan, RN		Joint Pain
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SAYRE
02/05/2019

Telephone Encounter - Jewell, Jan, RN - 02/05/2019 1:28 PM EST

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 2/5/2019

My Rheumatoid arthritis is really bothering me. I wake up in the morning and I'm having a very hard time getting out of bed and having difficulty after sitting on the couch. My shoulders, neck, and knees are hurting and I am very fatigued. Dr. Georgetson put me on Folic Acid and increased my Vitamin D. I just went and saw Dr. Gillan (my **PCP**) because I am struggling with brain fog and remembering. The muscle relaxer only temporarily relaxes me enough to sleep.

Should I come in and see you? I'm not due to come back until April. Message sent to Dr. Freeman, appointment given for 2/27/19

Robert Packer Hospital

02/01/2019

Progress Notes - Fritzen, Michael, PT - 02/01/2019 12:05 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
DISCHARGE Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 13

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1204

Time Out: 1220

Total Session Minutes: 16

Pain at Start of Care: 0/10

Pain at End of Care: 0/10

Subjective Comments:
Walking pain 0/10
Feels 95% better

Interventions:

Exercise #1
Exercise Name: Plantarfascia stretch

Exercise #2
Exercise Name: Standing wall push calf stretch with inv

Exercise #3
Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4
Exercise Name: Educated healthy eating and wt loss activity 150 minutes/wk of endurance and strength training
Details: understood

Normal **gait** pattern pain free

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long TErM Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- MET
- 4) resume walking dog pain limited -- MET

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 16
Total Treatment Minutes: 16

Author: Michael Fritzen, PT 2/1/2019 12:24

Electronically signed by Fritzen, Michael, PT at 02/01/2019 12:25 PM EST
01/31/2019 Office Visit Gillan, Michael F, DO

OSA (obstructive sleep apnea)
(PPrimary Dx);
Attention deficit hyperactivity disorder (ADHD), unspecified
ADHD type;
Grief reaction;
Family history of Marfan syndrome

SAYRE
01/31/2019

Progress Notes - Gillan, Michael F, DO - 01/31/2019 1:40 PM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/31/2019

CHIEF COMPLAINT:
Chief Complaint

Patient presents with

- Check Up

Patient here requestion genetic testing. C/O brain fog, difficulty focusing, and memory issues.

Subjective
HISTORY OF PRESENT ILLNESS:
Jennifer Lyn Brown is a 42-y.o. female.
HPI

1. Patient is here with the following concerns:

- Fatigued, brain fog, not sleeping well.
- Have trouble concentrating.
- States her symptoms started after the passing of her father. States that she notices they seem stable. States she feels like she is going through the normal grieving process. Notes she is concerned that she may have ADHD or recurrence of her sleep apnea. She was diagnosed with sleep apnea in 2013. Her CPAP titration note from 6/28/2018 states "Good response to CPAP. Consider CPAP at 14 cm of water pressure with heated humidifier, weight reduction program and good sleep hygiene."
- She notes she feels very similar to when she had undiagnosed sleep apnea.

Date	Type	Specialty	Care Team	Description
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				EXHIBIT NO. B2F PAGE: 71 OF 309

- She had gastric bypass laparoscopic sleeve gastrectomy on 6/10/2013.
- Her preoperative weight was 334 pounds, currently 289 pounds.
- She states she was told prior she didn't need the CPAP after surgery, thus has not been using it.
- She also requests genetic testing for Marfan syndrome, as her father passed away from this.

Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

The patient denies cough, chest pain, dyspnea, wheezing or hemoptysis.

The patient denies abdominal or flank pain, anorexia, nausea or vomiting, dysphagia, change in bowel habits or black or bloody stools or weight loss.

The patient denies any symptoms of neurological impairment or TIA's; no amaurosis, diplopia, dysphasia, or unilateral disturbance of motor or sensory function. No loss of balance or vertigo.

Sleep History and **Assessment:**
 Excessive Daytime sleepiness, Non restorative sleep, loud snoring.
 Symptoms for more than 30 days.
 ICD 10 Code: G47.33 with known severe sleep apnea.
 Mallampati score of 4.
 Epworth Sleepiness scale: 6 points.

MMSE: 29/30.

Does states she has history of ADHD as a child as well.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- CT** 2005
- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History
 Problem Relation Age of Onset
 • Diabetes Mother
 • Heart Mother
 • Hypertension Mother
 • Psychiatry Mother

Anxiety

• Arthritis Mother
 • Heart Disease Mother
 • Kidney Disease Mother
 • Diabetes Father
 • Hypertension Father
 • Genetic Father

Marfan syndrome

• Heart Father
 ?Marfan's Syndrome
 • Clotting Disorder Father
 • Heart Disease Father
 • Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

• Heart Disease Paternal Uncle
 • Diabetes Maternal Grandfather
 • Thyroid Disease Maternal Grandfather
 • Macular Degeneration Paternal Grandmother
 • Psychiatry Maternal Aunt

ADHD

• Genetic Maternal Aunt

Marfan syndrome

• Psychiatry Other

ADHD

• **Cancer** Paternal Grandfather
 • Glaucoma No family history
 • Blindness No family history
 • Other Eye Problems No family history
 • Anesth Problems No family history

Current Outpatient Medications

Medication Sig

• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
 • calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
 • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
 • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
 • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
 • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
 • ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
 • ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS for 4 doses.
 • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
 • foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
 • Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
 • Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
 • levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
 • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
 • loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
 • methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
 • Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
 • ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
 • pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
 • predniSONE (DELTASONE) 10 MG Oral Tab Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-GF Document 18 Filed 08/27/23 Page 401 of 1112				EXHIBIT NO. B2F PAGE 73 OF 309
				different. Begin 3 capsules each am. Reduce to 1 capsule daily every 210 days
				• Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
				• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
				• Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
				• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
				• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated

Spouse name: Not on file

- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity - worry: Not on file
- Food insecurity - inability: Not on file
- Transportation needs - medical: Not on file
- Transportation needs - non-medical: Not on file

Occupational History

- Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 oz

- Drug use: No
- Sexual activity: Yes

Partners: Male

Birth control/protecti on: Pill, Condom

Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Over the last 2 weeks, have you been feeling down, depressed, anxious, or hopeless?: 1

Over the past 2 weeks, have you felt little interest or pleasure in doing things?: 3

Trouble falling or staying asleep, or sleeping too much?: 3

Feeling tired or having little energy?: 3

Poor appetite or overeating?: 3

Feeling bad about yourself or that you are a failure or have let yourself or your family down?: 0

Trouble concentrating on things, such as reading the newspaper or watching TV?: 3

Moving or speaking so slowly that other people notice OR being fidgety and restless?: 2

Thoughts that you would be better off dead or of hurting yourself in some way?: 0

PHQ-9 TOTAL SCORE: 18

How difficult have these problems made it for you to do your work, take care of things at home or get along with people?: 397

Extremely difficult

In the past 2 years, have you felt depressed or sad most days, even if you felt ok?: No

A comprehensive review of systems was conducted with the patient and is negative unless noted above.

Objective

PHYSICAL EXAM:

VITALS: BP 122/72 (BP Location: Left arm, Patient Position: Sitting) | Pulse 92 | Temp 98.8 °F (37.1 °C) (Tympanic) | Resp 18 | Wt 289 lb (131.1 kg) | LMP 01/03/2019 (Approximate) | SpO2 97% Comment: room air | Breastfeeding? No | BMI 40.31 kg/m² Body mass index is 40.31 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

TM's clear bilaterally

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She displays normal reflexes. No cranial nerve deficit or sensory deficit. She exhibits normal muscle tone. Coordination normal.

Skin: Skin is warm and dry. No rash noted. No erythema. No pallor.

Psychiatric: Her speech is normal and behavior is normal. Judgment and thought content normal. Her mood appears not anxious. Her affect is not angry, not blunt, not labile and not inappropriate. She is not actively hallucinating. Cognition and memory are normal. She does not exhibit a depressed mood.

Still grieving the loss of her father. She is attentive.

Mallampati score of 4.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. OSA (obstructive sleep apnea) 327.23 G47.33 REFER TO SLEEP STUDY LAB
2. Attention deficit hyperactivity disorder (ADHD), unspecified ADHD type 314.01 F90.9 REFER TO PSYCHOLOGY
3. Grief reaction 309.0 F43.21 REFER TO PSYCHOLOGY
4. Family history of Marfan syndrome V19.5 Z82.79 REFER TO GENETICS

Plan

1. OSA:

- Severe on last titration study.
- States she was told by bariatrics she did not need this any longer.
- I believe she still has untreated sleep apnea, especially given her weight, symptoms, and prior diagnosis.
- I feel sleep study should be in the hospital given the high likely hood of sleep apnea and false negative rate of home sleep study.
- Patient agreeable, testing ordered.

2. Prior History of ADHD:

- Referred to Psychology for evalution.

3. Grief reaction:

- Elevated PHQ 9 with no thoughts of hurting self or others.
- Symptoms started after death of her father.
- Referred to Psychology.
- Will try melatonin for sleep at night.

4. Family history of Mental Syndrome.
- Reviewed prior cardiac testing.
- Referred to Genetics for testing.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

See Dr. Goldberg.

Obtain the Sleep Study.

Follow up in 1 month, sooner as needed.

Call with any questions or concerns.

Melatonin (By mouth)

Melatonin (mel-a-TOE-nin)

Treats insomnia.

Brand Name(s): Good Neighbor Pharmacy Melatonin, Nature's Blend Melatonin, PharmAssure Melatonin, Rite Aid Melatonin, Sundown Naturals Melatonin

There may be other brand names for this medicine.

When This Medicine Should Not Be Used:

You should not use this medicine if you have had an allergic reaction to melatonin.

How to Use This Medicine:

Capsule, Long Acting Capsule, Liquid, Tablet, Long Acting Tablet

- Your doctor will tell you how much medicine to use. Do not use more than directed.
- Follow the instructions on the medicine label if you are using this medicine without a prescription.
- Take your dose 20 minutes before your bedtime. You may take this medicine with or without food.
- The liquid may be taken directly or combined with water or juice.

If a dose is missed:

- If you miss a dose or forget to use your medicine, call your doctor or pharmacist for instructions.

How to Store and Dispose of This Medicine:

- Store the medicine in a closed container at room temperature, away from heat, moisture, and direct light.
- Keep all medicine out of the reach of children. Never share your medicine with anyone.
- Ask your pharmacist, doctor, or health caregiver about the best way to dispose of any outdated medicine or medicine no longer needed.

Drugs and Foods to Avoid:

Ask your doctor or pharmacist before using any other medicine, including over-the-counter medicines, vitamins, and herbal products.

- Make sure your doctor knows if you are also using any tranquilizer medicines, or if you are also using any sedative medicines.

Warnings While Using This Medicine:

- Make sure your doctor knows if you are pregnant or breast feeding, or if you have an autoimmune condition. Make sure your doctor knows if you are feeling sad or depressed.
- This medicine may make you drowsy. Avoid driving, using machines, or doing anything else that might be dangerous if you are not alert.

Possible Side Effects While Using This Medicine:

If you notice these less serious side effects, talk with your doctor:

- Feeling sluggish or tired in the morning.
- Headache.

If you notice other side effects that you think are caused by this medicine, tell your doctor.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088

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The above information is an educational aid only. It is not intended as medical advice for individual conditions or treatments. Talk to your doctor, nurse or pharmacist before following any medical regimen to see if it is safe and effective for you.

Author: Michael F Gillan, DO 2/5/2019 09:50

Electronically signed by Gillan, Michael F, DO at 02/05/2019 10:17 AM EST

Nursing Note - Prough, Shannon, LPN - 01/31/2019 1:40 PM EST

Check Up (Patient here requestion genetic testing. C/O brain fog, difficulty focusing,and memory issues.)

Author: Shannon Prough, LPN 1/31/2019 14:11

Electronically signed by Prough, Shannon, LPN at 01/31/2019 2:15 PM EST

01/31/2019	Telephone	Tracy, Marjorie	Insurance/Prior Authorization (sleep study change request)
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SAYRE
01/31/2019

Telephone Encounter - Tracy, Marjorie - 01/31/2019 3:20 PM EST

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/31/2019

Dr. Gillan
Without comorbidities that affect patient's breathing, and assuming she is capable of performing a home sleep test, Highmark guidelines for attended nocturnal poly are not met.
Will you please change your order to Home Sleep Test?
Thank you.

Author: Marjorie Tracy 1/31/2019 15:20

Electronically signed by Tracy, Marjorie at 01/31/2019 3:22 PM EST

01/28/2019	Telephone	Shaw, Beth, RN	Medication Question
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SAYRE
01/28/2019

Telephone Encounter - Shaw, Beth, RN - 01/28/2019 8:45 AM EST

"I finished the 50,000 unit of Vitamin D. There is a refill on it. Did Dr. Georgetson want me to refill it or go back to my normal Vitamin D?"

Thanks- Jen

Dr.Georgetson, please advise, thanks.
She has blood work due for vit D re-check 4/17/19.

Electronically signed by Shaw, Beth, RN at 01/28/2019 8:47 AM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 01/28/2019 9:03 AM EST

Refill and get a vit d level in one month

Electronically signed by Georgetson, Michael J, MD FACG at 01/28/2019 9:04 AM EST

Telephone Encounter - Shaw, Beth, RN - 01/28/2019 9:26 AM EST

Message left for patient to refill Vitamin D and have level drawn in 1 month. New lab order pending. Please review and sign order. Thanks.

Electronically signed by Shaw, Beth, RN at 01/28/2019 9:33 AM EST

Telephone Encounter - Shaw, Beth, RN - 01/28/2019 1:32 PM EST

Patient states she misread her direction for taking Vitamin D 50,000 - Take 1 Cap by mouth EVERY 7 DAYS. Take times 8

weeks. Patient took 1 cap every day for 1 week. States she has been having memory issues. Please advise. Thanks.

Electronically signed by Shaw, Beth, RN at 01/28/2019 1:41 PM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 01/28/2019 2:03 PM EST

Go to once per week per original directions

Electronically signed by Georgetson, Michael J, MD FACG at 01/28/2019 2:03 PM EST

Telephone Encounter - Shaw, Beth, RN - 01/28/2019 2:16 PM EST

Patient informed of Dr.Georgetson's recommendations. She will check with pharmacy to see when she can refill Vitamin D 50,000 units on a weekly basis. Do you still want her lab for Vit D level in 1 month or longer? Please advise, thanks.

Electronically signed by Shaw, Beth, RN at 01/28/2019 2:18 PM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 01/28/2019 2:45 PM EST

We can dispense one month of vit d (ie 4 pills) and check level in a month as she took a higher than expected dose

Electronically signed by Georgetson, Michael J, MD FACG at 01/28/2019 2:45 PM EST

Telephone Encounter - Shaw, Beth, RN - 01/28/2019 2:53 PM EST

Order pending. Please review and sign if in agreement. Patient also informed of Dr.Georgetson's recommendations in previous message.

Electronically signed by Shaw, Beth, RN at 01/28/2019 2:54 PM EST

Addendum Note - Shaw, Beth, RN - 01/28/2019 2:54 PM EST

Addended by: SHAW, BETH on: 1/28/2019 02:54 PM

Modules accepted: Orders

Electronically signed by Shaw, Beth, RN at 01/28/2019 2:54 PM EST

Addendum Note - Georgetson, Michael J, MD FACG - 01/28/2019 3:08 PM EST

Addended by: GEORGETSON, MICHAEL J on: 1/28/2019 03:08 PM

Modules accepted: Orders

Electronically signed by Georgetson, Michael J, MD FACG at 01/28/2019 3:08 PM EST

01/23/2019	Office Visit	Wagner, James, OT	Right elbow pain (Primary Dx)
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SAYRE

01/23/2019

Progress Notes - Wagner, James, OT - 01/23/2019 3:00 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
 Progress Note
 Outpatient Occupational **Therapy** Services
 SAYRE
 SAYRE OCCUPATIONAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-2201

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 1/23/2019

Referring Physician: Michael Gorsline

This progress report is for dates to 1/23/2019.

Total Visits Attended: 10

Subjective: " It still hurts."

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female who presents with chronic right lateral elbow pain.

Current Outpatient Medications:

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses., Disp: 12 mL, Rfl: 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- diclofenac (VOLTAREN) 1 % Transdermal Gel, 2 g by Topical route FOUR TIMES DAILY., Disp: 1 Tube, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting), Disp: 1 Each, Rfl: 3
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap, Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks., Disp: 8 Cap, Rfl: 1
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 5
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate, Disp: 100 Each, Rfl: 1
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly, Disp: 100 Each, Rfl: 0
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 84 Tab, Rfl: 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution, Inject 1 mL beneath the skin EVERY SATURDAY., Disp: 12 mL, Rfl: 1
- Nitroglycerin 0.4 % Rectal Ointment, Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator., Disp: 1 Tube, Rfl: 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- predniSONE (DELTASONE) 10 MG Oral Tab, Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking differently: 20 mg. Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days), Disp: 100 Tab, Rfl: 2
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks., Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS, Disp: 90 Cap, Rfl: 0
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 0

Current Facility-Adminis tered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
- Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2013
- with liver **biopsy**
- PR CLOSED RX TARSAL FX,EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
- for obesity - Dr. Alley - RPH

Measurement Data:

Edema: None noted at this time

Range of Motion: Right elbow flexion 140 degrees to -10 degrees
PROM > AROM

Strength Testing:
R - Grip #1: 20.5
Provocative testing for right lateral epicondylitis: 12.9lbs and + pain in lateral elbow.

L - Grip #1: 45.3

Sensation: No paresthesia in right UE.

Differential **Diagnosis:**
C/o nocturnal pain over dorsal forearm. + tenderness with palpation over supinator and lateral extensor wad, + middle finger extension test over supinator, pain with resisted supination in supinator. She reports feeling Of general "weakness" in right forearm and hand.
No report of radicular symptoms in right UE.

Radial tunnel vs. Lateral epicondylitis

Quick Dash:
Quick Dash
Open a tight or new jar: Unable
Do heavy Household chores (e.g. wash walls, floors): Moderate Difficulty
Carry a shopping bag or briefcase: Severe Difficulty
Wash your back: Moderate Difficulty
Use a knife to cut food: No Difficulty
Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, hammering, tennis, etc.): Unable
During the past week, to what extent has your arm, shoulder, or hand problem intefered with your normal social activities with family, friends, neighbors, or groups?: Quite a Bit
During the past week, were you limited in your work or other daily activities as a **result** of your arm, shoulder, or hand problem?: Moderately Limited
Rate the severity of the following symptoms in the last week: Arm, shoulder, or hand pain: Extreme
Rate the severity of the following symptoms in the last week: Tingling (pins and needles) in your arm, shoulder, or hand: None
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?: Moderate Difficulty
QuickDASH Score: 59.09

Impairment Observations: Pt. Has had 10 visits with no improvement. I recommend further **assessment** Pt. Will see orthopedic hand surgery and follow up with us after.

Goals:
Short Term:
1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks. (unmet)
2) Increase pain free grip 5 lbs in right hand 2-3 weeks. (unmet)
3) Decrease mechanical elbow pain to 4/10 2-3 weeks. (unmet)

Long Term:
1) Pt. will be able to sleep t/out the night without pain at time of D/C. (unmet)

Interventions/Pl an: D/C. Pt. Feels she would Like to get an opinion in hand surgery. Pt. Will continue with nerve glides, stretch, activity modification and orthosis PRN for pain control.

Patient concurs with established treatment and goals.

Total Timed Code Minutes: 0
Total Treatment Minutes: 30

01/23/2019

Lab

01/23/2019

Telephone

Gillan, Michael F, DO

Annual physical exam

SAYRE

01/23/2019

Telephone Encounter - Gillan, Michael F, DO - 01/23/2019 9:05 AM EST

Name: Jennifer Lyn Brown

DOB: 10/26/1976

MRN: 340616

Date of Service: 1/23/2019

Patient has an upcoming appointment with me.

- She is requesting a mayo consult as per the schedule.

- I am not able to do a mayo consult as primary care.

- I can try to refer her to a specialist who can when I see her.

- Please inform patient.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 01/23/2019 9:12 AM EST

Telephone Encounter - Prough, Shannon, LPN - 01/23/2019 9:17 AM EST

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 1/23/2019

Sent an eguthrie informing patient.

Author: Shannon Prough, LPN 1/23/2019 09:17

Electronically signed by Prough, Shannon, LPN at 01/23/2019 9:17 AM EST

01/23/2019

Orders Only

Bailey, Cathryn, LPN

01/18/2019

Telephone

Prough, Shannon, LPN

Care Team Huddle

SAYRE

01/18/2019

Telephone Encounter - Prough, Shannon, LPN - 01/18/2019 1:09 PM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 1/18/2019

The following care gaps were discussed during the care team huddle:

BP Readings from Last 1 Encounters:

01/02/19 130/70

Care Team members present: Provider and Nurse

Author: Shannon Prough, RN at 01/18/2019 1:10 PM EST
Electronically signed by Prough, Shannon, LPN at 01/18/2019 1:10 PM EST

01/16/2019 Telephone Shaw, Beth, RN

SAYRE
01/16/2019

Telephone Encounter - Shaw, Beth, RN - 01/16/2019 3:59 PM EST

Patient complains of feeling exhausted on a daily basis. States she has currently been very stressed due to recent death of her father and assuming care of her house bound mother.
Per patient, "I am just dragging. I can barely get up in the morning. I am in bed early. I even sleep on the way to work while Jonathan drives me. No matter what, I feel like I am dragging. I know I've been through a lot of stress lately, but there hasn't been one day where I have felt rested".
Patient denies any rectal bleeding or heavy periods. States she is eating appropriately. Sleeping through the night at least 8 hours.
Dr. Georgetson, please advise, thanks.

Electronically signed by Shaw, Beth, RN at 01/16/2019 4:03 PM EST

Telephone Encounter - Shaw, Beth, RN - 01/16/2019 4:04 PM EST

Formatting of this note might be different from the original.

Georgetson, Michael J, MD FACG Shaw, Beth, RN

It could be stress
Let's have her get some labs
CBC
CMP
CRP
ESR

Orders pending. Please review and sign.
Patient states she used CPAP prior to Bariatric surgery but not since.
Has office visit scheduled with her **PCP** for Friday, 1/18/19.

Electronically signed by Shaw, Beth, RN at 01/16/2019 4:10 PM EST

Telephone Encounter - Shaw, Beth, RN - 01/17/2019 9:36 AM EST

Orders pending. Please review and sign. Thanks.

Patient denies worsening of symptoms today. Denies any shortness of breath. States she just feels exhausted and wants to sleep.
Patient verbalized she will wait to have GI ordered labs drawn until after **PCP** appointment tomorrow, in case additional labs are requested.

Electronically signed by Shaw, Beth, RN at 01/17/2019 9:42 AM EST

Telephone Encounter - Shaw, Beth, RN - 01/17/2019 4:25 PM EST

Notes recorded by Georgetson, Michael J, MD FACG on 1/17/2019 at 2:32 PM EST
 The CBC indicates no anemia
 The ESR is normal
 The CRP is up a bit to
 ~1.1 c/w an inflammatory response
 The CMP does not reveal any significant anomalies

The vit d level is low. I would suggest Vit D 50000 units once per week with a recheck of Vit D levels in 3 months

In addition, as she is on MTX, I would suggest Folic acid 1 mg daily for as long as she is on the MTX

Electronically signed by Shaw, Beth, RN at 01/17/2019 4:29 PM EST

Addendum Note - Shaw, Beth, RN - 01/17/2019 4:29 PM EST

Addended by: SHAW, BETH on: 1/17/2019 04:29 PM

Modules accepted: Orders

Electronically signed by Shaw, Beth, RN at 01/17/2019 4:29 PM EST

Addendum Note - Georgetson, Michael J, MD FACG - 01/17/2019 4:34 PM EST

Addended by: GEORGETSON, MICHAEL J on: 1/17/2019 04:34 PM

Modules accepted: Orders

01/15/2019	Office Visit	Smith, Rebecca, COTA/L	Right elbow pain (Primary Dx)
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SAYRE
01/15/2019
Progress Notes - Smith, Rebecca, COTA/L - 01/15/2019 11:30 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Occupational **Therapy** Services
 SAYRE
 SAYRE OCCUPATIONAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-2201
 Fax 570-887-2213

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 1/15/2019

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
 ICD-9-CM ICD-10-CM
 1. Right elbow pain 719.42 M25.521

Subjective Comments: "Im not too bad yet but Ive been making a more conscious effort to pick things up differently and Im exercising throughout the day at work and I think Its a little better. I find that on the days when Im not working I dont have as

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. Hi story of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**.

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1129

Time Out: 1210

Visit Number: 9

Pain at the START of Treatment: 2/10

Pain at the END of Treatment: 6/10

Modalities Needed?: Ultrasound;Moist Heat;Light **Therapy**/Infared

Ultrasound (97035)

Body Area: right lateral epicondyle

Frequency: 3.3 MHz

Frequency Description: Continuous

Intensity: 0.8cm2

Total Minutes: 10

Moist Heat (97010)

Body Area: right elbow

Total Minutes: 10

Light **Therapy**/Infared (97026)

Body Part: right lateral and medial epi

Mode: Light Pad

Light Used: Red;Infared

Dosage J/cm2: 10j2

Total Minutes: 10

Manual **Therapy** (97140)

Soft Tissue Mobilization: IASTM

Instrument-Assis ted Soft Tissue Mobilization: used hawk grip multi tool

Body Area: right lateral epi and dorsal forerarm

Description: sweeping strokes distal to proximal and then short strums over the lateral epi

Total Minutes (All Manual **Therapy**): 10

Therapeutic Exercises (97110)

Additional Exercises: phase 4 of wrist flexion prolonged stretches and then eccentric loading with a 2 lb dumb bell for 3 sets of 10

Wrist/Forearm ROM: wrist flexion stretch with outstretched arm for prolonged holds of 30 sec x 6

Wrist/Forearm Strengthening: eccentric loading with 2 lb weight 3 x 10

Total Minutes: 15

Intervention Comments: Pt reported more pain today after txm and stated she was more stiff

Goals:

Short Term:

- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
- 2) Increase pain free grip 5 lbs in right hand 2-3 weeks.
- 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term:

- 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Cont with POC 2-3 x wk

Total UNTIMED Code Minutes: 10

Total TIMED Code Minutes: 35

Author: Rebecca Smith, COTA/L 1/15/2019 12:36

Electronically signed by Smith, Rebecca, COTA/L at 01/15/2019 12:42 PM EST

Office Visit

Smith, Rebecca, COTA/L

Right elbow pain (Primary Dx)

SAYRE
01/08/2019

Progress Notes - Smith, Rebecca, COTA/L - 01/08/2019 11:00 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-2201
Fax 570-887-2213

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 1/8/2019

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521

Subjective Comments: "Im already sore and my day has just started. Im starting to have the same pain in the left elbow."

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**. Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1110
Time Out: 1200

Visit Number: 8

Pain at the START of Treatment: 3/10
Pain at the END of Treatment: 0/10

Modalities Needed?: Ultrasound;Moist Heat;Light **Therapy**/Infared

Ultrasound (97035)
Body Area: right lateral epicondyle
Frequency: 3.3 MHz
Frequency Description: Continuous
Intensity: 0.8cm2
Total Minutes: 10

Moist Heat (97010)
Body Area: right elbow
Total Minutes: 10

Light **Therapy**/Infared (97026)
 Body Part: right lateral and medial epi
 Mode: Light Pad
 Light Used: Red;Infared
 Dosage J/cm2: 10j2
 Total Minutes: 10

Manual **Therapy** (97140)
 Soft Tissue Mobilization: IASTM
 Instrument-Assis ted Soft Tissue Mobilization: used hawk grip multi tool
 Body Area: right lateral epi and dorsal forerarm
 Description: sweeping strokes distal to proximal and then short strums over the lateral epi
 Total Minutes (All Manual **Therapy**): 10

Therapeutic Exercises (97110)
 Additional Exercises: pt instructed today in phase 4 of wrist flexion prolonged stretches and then eccentric loading with a 2 lb dumb bell for 3 sets of 10
 Wrist/Forearm ROM: wrist flexion stretch with outstretched arm for prolonged holds of 30 sec x 6
 Wrist/Forearm Strengthening: eccentric loading with 2 lb weight 3 x 10
 Total Minutes: 15

Intervention Comments: Pt tolerated txm well today. Instructed in new HEP and pt was able to recall to me

- Goals:
- Short Term:
- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
 - 2) Increase pain free grip 5 lbs in right hand 2-3 weeks.
 - 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

- Long Term:
- 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Cont with POC 2-3 x wk

Total UNTIMED Code Minutes: 20
 Total TIMED Code Minutes: 35
 Total Treatment Minutes: 55
 Author: Rebecca Smith, COTA/L 1/8/2019 12:01

Electronically signed by Smith, Rebecca, COTA/L at 01/08/2019 1:34 PM EST
 Hospital Encounter

Fritzen, Michael, PT

Repeat Series

01/07/2019

Robert Packer Hospital
01/07/2019

Progress Notes - Fritzen, Michael, PT - 01/07/2019 4:33 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
 REASSESSMENT Note
 Outpatient Physical **Therapy** Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Treatment Number: 12

Referring Physician: Michael Gorsline

Time In: 1632

Time Out: 1700

Total Session Minutes: 28

Pain at Start of Care: 3/10

Walking 3/10

Pain at End of Care: 1/10

Subjective Comments:

Her dad passed away > been very busy helping to care for mom and stressful

Foot still hurting in mid foot

Night pain beginning of night

1st step pain better

Interventions:

Therapeutic Exercises (97110)

Number of Exercises?: 5

Total Minutes (all Therapeutic Exercise): 13

Exercise #1

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4

Exercise Name: Educated shoe styles

Manual **Therapy** (97140)

Soft Tissue Mobilization Details: L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm2 5:00 and Graston #4 sweeps

PROM: Plantar fascia stretches

Joint Mobilization: L: `Posterior Talar glides , Talo-cural distraction

Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm2 L plantar fascia with stretch

Total Minutes (All Manual **Therapy**): 15

Assessment: We evaluated Mrs. Brown in PT 9/12/18 and have seen her 12 tx, 2nd to L Plantar fascitis. She was doing well, but recently her pain returned some 2nd to father dying and her not doing HEP as much. She is wearing minimalist style shoe and this has no intrinsic stability > I would recommend a Neutral shoe. She also needs to perform a wt loss program > this will help to decrease amount of force impact. If pain not better than she might benefit from custom orthotics > we will continue to follow 1/ 2wks. Her ROM is good and she doe not have any excessive pronation noted. Patient also reports ongoing difficulty in walking.

Short Goals: (2-4 wks)

1) IND education -- MET

2) IND 1st step pain control -- MET

3) decrease pain 25% end of day -- MET

Long TErM Goals: (2-3 months)

- Decrease pain 20% end of day -- MET
- Intermittent pain walking -- MET
- increase functional status 24 points per FOTO survey -- PROGRESSING
- resume walking dog pain limited -- Not Met

Plan for Next Visit: See above

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 28
Total Treatment Minutes: 28

Author: Michael Fritzen, PT 1/7/2019 17:14

Electronically signed by Fritzen, Michael, PT at 01/07/2019 5:20 PM EST

Therapy Plan of Care - Fritzen, Michael, PT - 01/07/2019 5:18 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Re-Evaluation Plan of Care
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 1/7/2019

Referring Physician: Michael Gorsline

Plan of Care Start Date: 01/07/19

Plan of Care Expiration Date: 04/07/19

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Plantar fascial fibromatosis 728.71 M72.2

Prior Functional Status: walking a lot

Current Functional Status:
not walking dog

Rehabilitative **Prognosis**: Good

Goals:
Short Goals: (2-4 wks)
1) IND education -- MET
2) IND 1st step pain control -- MET
3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)
1) Decrease pain 50% end of day -- MET
2) Intermittent pain walking -- MET
3) increase functional status 24 points per FOTO survey -- PROGRESSING
4) resume walking dog pain limited -- NOT MET

Planned Intervention(s): **Gait** Training (97116);Therapeu tic Activity (Timed) (97530);Therapeu tic Exercise (Timed)

Frequency of Treatment: Other (see Comment)(1/1-3 wks)

Duration of Treatment: 3 months

The Physical **Therapy** Plan of Care has been discussed with the patient . Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical **Therapy** treatment while under my care.

Gorsline, Michael, PA-C
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: Michael Fritzen, PT 1/7/2019 17:20

Electronically signed by Gorsline, Michael, PA-C at 01/08/2019 10:28 AM EST

Gastro
Nurse/clinical
support

Crohn's disease with other
complication, unspecified
gastrointestinal tract location
(HCC) (Primary Dx)

SAYRE
01/07/2019

Nursing Note - Shaw, Beth, RN - 01/07/2019 9:00 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/7/2019

SUBJECTIVE:
Jennifer Lyn Brown is a 42-y.o. female patient of Dr. Michael Georgetson. She comes to Department of Gastroenterology on 1/7/2019 for education regarding starting Her Stelara injections for Crohn's disease. Most recently Jennifer Lyn Brown has a history of:

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- CT** 2005
- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008

- HTN (hypertension), benign 10/7/2008
 - Hypertension
 - Morbidly obese (HCC)
 - Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

CURRENT MEDICATIONS:

Current Outpatient Medications

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- diclofenac (VOLTAREN) 1 % Transdermal Gel 2 g by Topical route FOUR TIMES DAILY.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- predniSONE (DELTASONE) 10 MG Oral Tab Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking differently: 20 mg. Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days)
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

ALLERGIES:

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

PHYSICAL EXAMINATION:

There were no vitals taken for this visit.

Date	Type	Specialty	Care Team	Description
01/07/2019	Telephone	Gastroenterology	Shaw, Beth, RN	Today's visit was spent reviewing Stelara therapy and Stelara injection technique. Jennifer Lyn Brown was instructed and received one subcutaneous injection to her left upper arm via 45 degree angle, for a dose of 90 mg. She tolerated this well. Lot number for the Stelara was ICS2ZML. Expiration 02/2021. She remained in the Department for approximately 30 minutes status post injection. She denies any side effects upon leaving.

ASSESSMENT AND PLAN:

Jennifer Lyn Brown was instructed to contact our office with any questions or concerns. Her next injection will be Stelara 90 mg subcutaneous injection done again through a nurse visit in the Department of Gastroenterology with her significant other present for additional teaching. Patient would like her significant other to learn how to give Stelara injection to her upper arms. Her Stelara injection will be every 8 weeks.

AUTHOR:

Beth Shaw, RN
SECTION OF GASTROENTEROLOGY
1/7/2019 14:31

Electronically signed by Shaw, Beth, RN at 01/07/2019 3:01 PM EST
Telephone Shaw, Beth, RN Follow Up

SAYRE
01/07/2019

Telephone Encounter - Shaw, Beth, RN - 01/07/2019 11:21 AM EST

Stelara infusion on 11/12/18. 8 weeks f/u nurse visit today for Stelara injection teaching. Patient temperature 100.1, denies illness at present. Please advise if okay to proceed with Stelara today. Thanks.

Electronically signed by Shaw, Beth, RN at 01/07/2019 11:25 AM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 01/07/2019 11:40 AM EST

In the absence of any other symptoms and with a temp only mildly above her norm
I think we can go ahead

Electronically signed by Georgetson, Michael J, MD FACG at 01/07/2019 11:40 AM EST

Telephone Encounter - Shaw, Beth, RN - 01/14/2019 9:41 AM EST

Last CBC/CMP on 11/12/18. Standing orders pending for every 3 month labs. Please advise if any other recommendations, other labs, etc.

Status report: Spoke w/ pt 1/14/19

Patient states she is not feeling any improvement yet since starting Stelara, (1st dose - infusion 11/12/18). Patient instructed to schedule f/u office visit with GI provider. Also to schedule repeat nurse visit for injection teaching with significant other on or around 3/4/19.

Electronically signed by Shaw, Beth, RN at 01/14/2019 10:01 AM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 01/14/2019 10:45 AM EST

Set up NP appt

Electronically signed by Georgetson, Michael J, MD FACG at 01/14/2019 10:46 AM EST

Telephone Encounter - Williams, Kimberly, RN - 01/14/2019 11:34 AM EST

Kim,
Can you please arrange an NP appointment per Dr. Georgetson? Thanks.

Electronically signed by Williams, Kimberly, RN at 01/14/2019 11:35 AM EST

Telephone Encounter - Gromes, Kimberly - 01/16/2019 1:28 PM EST

Pt making her own apt

Electronically signed by Gromes, Kimberly at 01/16/2019 1:28 PM EST

SAYRE
01/02/2019

Progress Notes - Regmi, Asish, MD - 01/02/2019 3:00 PM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/2/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with
• Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female is here for regular follow up visit.

HPI

Jennifer Lyn Brown is a 42-y.o. Female With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira, now changed to Ustekinumab by GI, methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Patient was seen here on sept for flare up.

Patient has also been following GI for crohn's disease.

Patient said that after she was started on Ustekinumab her swelling has gone better she still has pain.

She has pain in her wrist and knuckles. The pain is usually worst in the morning and she also has stiffness with it, and slowly gets better after day progress.

She says that she has been on stress lately because her father passed away and was taking her prednisone for few days and which caused her pain to get worsen.

In her recent lab anti histone and ANA were positive.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)

- Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

- Family History
- Problem Relation Age of Onset
- Diabetes Mother
 - Heart Mother
 - Hypertension Mother
 - Psychiatry Mother

- Anxiety**
- Arthritis Mother
 - Heart Disease Mother
 - Kidney Disease Mother
 - Diabetes Father
 - Hypertension Father
 - Genetic Father

- Marfan syndrome
- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle
- Aortic Dissection, Marfan's Syndrome
- Heart Disease Paternal Uncle
 - Diabetes Maternal Grandfather
 - Thyroid Disease Maternal Grandfather
 - Macular Degeneration Paternal Grandmother
 - Psychiatry Maternal Aunt

- ADHD
- Genetic Maternal Aunt
- Marfan syndrome
- Psychiatry Other
- ADHD
- **Cancer** Paternal Grandfather
 - Glaucoma No family history
 - Blindness No family history
 - Other Eye Problems No family history
 - Anesth Problems No family history

- Current Outpatient Medications
- Medication Sig
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
 - calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
 - Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
 - cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
 - cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
 - diclofenac (VOLTAREN) 1 % Transdermal Gel 2 g by Topical route FOUR TIMES DAILY.
 - EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
 - fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
 - Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS.
- Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use

- with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
 - lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
 - loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
 - methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
 - Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
 - ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
 - pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
 - predniSONE (DELTASONE) 10 MG Oral Tab Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking differently: 20 mg. Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days)
 - Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
 - Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
 - Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
 - venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
 - venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Adminis tered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated

Spouse name: Not on file

- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity - worry: Not on file
- Food insecurity - inability: Not on file
- Transportation needs - medical: Not on file
- Transportation needs - non-medical: Not on file

Occupational History

- Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 oz

- Drug use: No
- Sexual activity: Yes

Partners: Male

Birth control/protecti on: Pill, Condom

Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Constitutional: Negative for chills, fever and weight loss.
HENT: Negative for ear pain, hearing loss and tinnitus.
Eyes: Negative for blurred vision, double vision and photophobia.
Respiratory: Negative for cough, hemoptysis and sputum production.
Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.
Gastrointestinal : Negative for heartburn, nausea and vomiting.
Genitourinary: Negative for dysuria, frequency and urgency.
Musculoskeletal: Positive for joint pain.
Skin: Negative for itching and rash.
Neurological: Negative for dizziness, tingling and headaches.
Endo/Heme/Allerg ies: Negative for environmental allergies. Does not bruise/bleed easily.

Objective

PHYSICAL EXAM:

VITALS: BP 130/70 | Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m² Body mass index is 39.89 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate and regular rhythm. Exam reveals no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema.

Tenderness in wrist joint.

Tender point in shoulder and hip as well

Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit. Coordination normal.

Skin: Skin is warm and dry.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) 714.0 M05.731
M05.732

Plan

Rheumatoid arthritis:

Recently changed from humeria to UStekinumab by GI.

Still having some pain.

Still on tapering steroids.

Patient also no methotrexate.

Patient to continue with same medication.

Fibromyalgia:

She has tender points in her body.

Most likely has some component of fibromyalgia.

Will start her on flexeril for now. Her **PCP** to decide on further medication.

Follow in 4 months.

D/W Dr freeman and agreed upon.

Author: Asish Regmi, MD 1/2/2019 15:49

Electronically signed by Regmi, Asish, MD at 01/13/2019 6:06 PM EST

Progress Notes - Freeman, James, MD - 01/02/2019 3:00 PM EST

I saw and evaluated the patient. Discussed with resident and agree with the resident's **findings** and plan as documented in the resident's note.

Electronically signed by Freeman, James, MD at 01/16/2019 1:18 PM EST	
Office Visit	Wagner, James, OT Right elbow pain (Primary Dx)

SAYRE
01/02/2019

Progress Notes - Wagner, James, OT - 01/02/2019 11:30 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 1/2/2019

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521

Subjective Comments: " I dont know if this is helping. It feels better afterward but comes back."

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1130
Time Out: 1200

Visit Count: 7

Pain at the START of Treatment: 7/10
Pain at the END of Treatment:

Iontophoresis (97033)
Body Area: right elbow (treatment #6)
Medication Used: Dexamethasone
Volume: 2.0cc
Dose mA x min: 80
Current: 3.5
Skin Condition Post-Treatment: no blistering, only mild redness
Total Minutes: 24

Intervention Comments: Minimal lasting improvement with dexamethasone related to pain.

Goals:

Short Term:

- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
- 2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
- 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Plan: D/C use of iontophoresis and begin use modalities and soft tissue mobility with exercise starting next visit.

Total UNTIMED Code Minutes: 0
Total TIMED Code Minutes: 24
Total Treatment Minutes: 24

Author: James Wagner, OT 1/2/2019 11:38

Electronically signed by Wagner, James, OT at 01/02/2019 11:54 AM EST

12/31/2018	Refill	Gillan, Michael F, DO	GAD (generalized <u>anxiety</u> disorder)
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SAYRE
12/31/2018

Telephone Encounter - Brown, Miranda, LPN - 12/31/2018 10:31 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 12/31/2018

Requested Prescriptions

Pending Prescriptions Disp Refills
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR [Pharmacy Med Name: VENLAFAXINE HCL ER 150 MG CAP] 90 Cap 0
Sig: TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS

Medication refused, refilled today 12/31/18.

Author: Miranda Brown, LPN 12/31/2018 10:31

Electronically signed by Brown, Miranda, LPN at 12/31/2018 10:32 AM EST

12/30/2018	Refill	Gillan, Michael F, DO	GAD (generalized <u>anxiety</u> disorder)
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SAYRE
12/30/2018

Telephone Encounter - Myers, Thomas, LPN - 12/31/2018 8:15 AM EST

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 12/31/2018

Last seen 11/21/2018 last filled 9/10/2018

Next app 1/18/2019 Dr. Gillan

venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR

Author: Thomas Myers, LPN 12/31/2018 08:15

Electronically signed by Myers, Thomas, LPN at 12/31/2018 8:16 AM EST

Telephone Encounter - Gillan, Michael F, DO - 12/31/2018 8:21 AM EST

Name: Jennifer Lyn Brown
 DOB: 10/26/1976
 MRN: 340616
 Date of Service: 12/30/2018

Refilled after chart review, has upcoming appointment.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 12/31/2018 8:22 AM EST

12/28/2018	Office Visit	Fox, Melissa, OTR/L	Right elbow pain (Primary Dx); Right tennis elbow
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SAYRE

12/28/2018

Progress Notes - Fox, Melissa, OTR/L - 12/28/2018 10:30 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Occupational **Therapy** Services
 SAYRE
 SAYRE OCCUPATIONAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-2201
 570-888-5858

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 12/28/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
 ICD-9-CM ICD-10-CM
 1. Right elbow pain 719.42 M25.521
 2. Right tennis elbow 726.32 M77.11

Subjective Comments: Patient reports some relief after the last session but it was very short period of reduced pain.

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**.

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1030
 Time Out: 1105

Visit Count: 6 (5th into)

Pain at the START of Treatment: 4/10
 Pain at the END of Treatment: 4/10

Precautions: None

Iontophoresis (97033)
 Body Area: right elbow (treatment #3)
 Medication Used: Dexamethasone
 Volume: 2.0cc
 Dose mA x min: 60
 Current: 3.0(Patient reports this was done on the last session)
 Skin Condition Post-Treatment: no blistering, only mild redness
 Total Minutes: 24

Intervention Comments: Patient has had very little change in her pain with use of iontophoresis. She is scheduled with the evaluating therapist for next week to assess progress and discuss the plan of care.

- Goals:
- Shor t Term:
- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
 - 2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
 - 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

- Long Term:
- 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Patient will follow up with evaluating therapist next week to discuss plan of care.

Total UNTIMED Code Minutes:
 Total TIMED Code Minutes: 24
 Total Treatment Minutes: 24

Author: Melissa Fox, OTR/L 12/28/2018 11:15

Electronically signed by Fox, Melissa, OTR/L at 12/28/2018 11:18 AM EST
 Office Visit Perkins, Christopher, OT Right elbow pain (Primary Dx)

12/26/2018

SAYRE

12/26/2018

Progress Notes - Perkins, Christopher, OT - 12/26/2018 12:00 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Occupational **Therapy** Services
 SAYRE
 SAYRE OCCUPATIONAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-2201
 570-888-5858

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 12/26/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
 ICD-9-CM ICD-10-CM
 1. Right elbow pain 719.42 M25.521

Subjective Comments:

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1200
Time Out: 1230

Visit Count: 5 (4rd into)

Pain at the START of Treatment: 4/10
Pain at the END of Treatment: 1/10

Modalities Needed?: Iontophoresis
Iontophoresis (97033)
Body Area: right elbow (treatment #3)
Medication Used: Dexamethasone
Volume: 2.0cc
Dose mA x min: 60
Current: 3.0
Skin Condition Post-Treatment: no blistering, only mild redness
Total Minutes: 24

Precautions: None

Intervention Comments: Patient reports less pain post treatment

- Goals:
- Short Term:
- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
 - 2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
 - 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

- Long Term:
- 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Cont with POC 2-3 x wk

Total UNTIMED Code Minutes:
Total TIMED Code Minutes: 24
Total Treatment Minutes: 24

Author: Christopher Perkins, OT, CHT 12/26/2018 12:13

Electronically signed by Perkins, Christopher, OT at 12/26/2018 2:16 PM EST
Office Visit

Fox, Melissa, OTR/L

Right elbow pain (Primary Dx);
Right tennis elbow

SAYRE

12/24/2018

Progress Notes - Fox, Melissa, OTR/L - 12/24/2018 11:30 AM EST

Formatting of this note might be different from the original.

SAYRE PA 18840-1625
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-2201
 570-888-5858

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 12/24/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis:**
 ICD-9-CM ICD-10-CM
 1. Right elbow pain 719.42 M25.521
 2. Right tennis elbow 726.32 M77.11

Subjective Comments: Patient reports little change overall in her lateral elbow pain.

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**.

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1120
 Time Out: 1200

Visit Count: 5 (3rd ionto)

Pain at the START of Treatment: 5/10
 Pain at the END of Treatment: 2/10

Precautions: None

Modalities Needed?: Iontophoresis
 Iontophoresis (97033)
 Body Area: right elbow (treatment #3)
 Medication Used: Dexamethasone
 Volume: 2.0cc
 Dose mA x min: 60
 Current: 2.0
 Skin Condition Post-Treatment: no blistering, only mild redness
 Total Minutes: 30

Intervention Comments: Patient reports little change in her pain at this time. I educated her that it can take several treatments to feel a change in pain long term. Will continue with iontophoresis for now.

Goals:
 Short Term:
 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
 2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term:
 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Cont with POC 2-3 x wk

Total UNTIMED Code Minutes:
 Total TIMED Code Minutes: 30
 Total Treatment Minutes: 30

- Sees Dr. Preetika Sinha
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
 - EGD 2002
 - EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
- Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- EGD (GUTHRIE / NON GUTHRIE)
 - LAPAROSCOPIC CHOLECYSTECTOMY 2013
- with liver **biopsy**
- PR CLOSED RX TARSAL FX,EACH
 - PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
- for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
 - TONSILLECTOMY 11/26/07

Outpatient Medications Marked as Taking for the 12/21/18 encounter (Office Visit) with Shady, Timothy, FNP-C
Medication Sig Dispense Refill

- nitrofurantoin monohydrate macrocrystal (MACROBID) 100 MG Oral Cap Take 1 Cap by mouth TWICE DAILY for 5 days. 10 Cap 0

Current Facility-Adminis tered Medications for the 12/21/18 encounter (Office Visit) with Shady, Timothy, FNP-C
Medication Dose Route Frequency Provider Last Rate Last Dose

- saline (OCEAN) nasal spray 0.65 % 2 Spray Nasal Q2H PRN Braslow, Matthew Lim, DO

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

ROS: Reviewed in HPI and pertinent positives noted above, remaining are negative if not otherwise stated.

PHYSICAL EXAM:

OBJECTIVE:

BP 124/72 Pulse 105 Temp 99.2 °F (37.3 °C) (Tympanic) Resp 20 SpO2 97%

GENERAL: Alert, In no acute distress

HEAD: Atraumatic

CHEST/LUNGS: Resps easy and unlabored. Clear to auscultation bilaterally. No wheezes, rales, rhonchi.

HEART: Regular rate and rhythm. No abnormal heart sounds appreciated

ABDOMEN: Soft, mild suprapubic tenderness. BS x 4 normoactive. No guarding, rebound tenderness, or rigidity. No CVA tenderness

INTEGUMENTARY: Skin pink, warm

Results for orders placed or performed in visit on 12/21/18

URINE DIPSTICK (AMB POCT)

Result Value Ref Range

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGE Document 18 Filed 08/27/23 Page 432 of 1112				
	URINE CULTURE (POCT) Negative Negative			EXHIBIT NO. B2F
	URINE BILIRUBIN (POCT) Negative Negative			PAGE: 104 OF 309
	Urine Ketones (POCT) Negative Negative			
	URINE SPECIFIC GRAVITY (POCT) 1.015 1.005 - 1.030			
	URINE BLOOD (POCT) Trace-Intact (A) Negative			
	URINE PH (POCT) 6.0 5.0 - 8.0			
	URINE PROTEIN (POCT) Negative Negative mg/dl			
	URINE UROBILINOGEN (POCT) 0.2 0.2 - 1.0 mg/dl			
	URINE NITRITES (POCT) Negative Negative			
	URINE LEUKOCYTES (POCT) Small (A) Negative			

ASSESSMENT:

ICD-9-CM ICD-10-CM

1. Dysuria 788.1 R30.0 URINE DIPSTICK (AMB POCT)

URINE CULTURE (C&S)

nitrofurantoin monohydrate macrocrystal (MACROBID) 100 MG Oral Cap

PLAN:

Patient Instructions

Good handwashing to prevent the spread of germs, and avoid crowds and sick contacts to lesson future illness.

Drink plenty of fluids, get plenty of rest.

The following medications were eprescribed to your pharmacy:

Macrobid twice daily as prescribed

Take a probiotic or yogurt with active cultures as we discussed.

Pick up at the pharmacy/ Over the counter medications Recommended:

Acetaminophen decreases pain and fever. It is available without a doctor's order. Ask how much to take and how often to take it. Follow directions. Acetaminophen can cause liver damage if not taken correctly.

NSAIDs (Ibuprofen, Motrin, Aleve) decrease swelling and pain or fever. This medicine can be bought with or without a doctor's order. This medicine can cause stomach bleeding or kidney problems in certain people. If you take blood thinner medicine, always ask your healthcare provider if NSAIDs are safe for you. Always read the medicine label and follow the directions on it before using this medicine.

Labs/cultures ordered/taken today:

Urine culture: Final **result** will be available in 48-72 hours; If we need to change your antibiotic, we will notify you, or if you are having ongoing issues in 2-3 days, you may call the walk in office at 570.887.2383 for final **results**

If any labs, xrays, cultures have been completed today any concerning **results** will be called to you. You may check your online Eguthrie account in the next several days for **results** also.

Avoid cigarette smoke, fumes, dust and other respiratory irritants, as these can worsen your cough.

Follow up with your primary care provider, or Family Practice (570)887-2239 within the timeframe discussed, or present to the Emergency Room with any sudden worsening or other concerns.

It was my pleasure evaluating you in the Sayre Walk in Care office today.

Sayre Walk in Hours: Monday- Friday 7am-8pm and Saturday/Sunday 8am-12pm

Thank you for choosing the Sayre Walk In Clinic for your needs today!

We hope you are feeling better soon!

Timothy Shady, FNP-C

ACT Phone Number (570)887-2383

Timothy Shady, FNP-C 12/21/2018 11:49

Electronically signed by Shady, Timothy, FNP-C at 12/21/2018 11:49 AM EST

Nursing Note - Chandler, Marsha, LPN - 12/21/2018 11:10 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 12/21/2018

Chief Complaint
Patient presents with
• Dysuria

Author: Marsha Chandler, LPN 12/21/2018 11:14

Electronically signed by Chandler, Marsha, LPN at 12/21/2018 11:27 AM EST

12/19/2018 Office Visit Smith, Rebecca, COTA/L Right elbow pain (Primary Dx)

SAYRE
12/19/2018

Progress Notes - Smith, Rebecca, COTA/L - 12/19/2018 11:00 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 12/19/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521

Subjective Comments: "I really ached later in the day after the first txm"

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**. Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1120

Visit Count: 4 2nd ionto today

Pain at the START of Treatment: 1/10
Pain at the END of Treatment: 1/10

Modalities Needed?: Iontophoresis

Iontophoresis (97033)
Body Area: right elbow
Medication Used: Dexamethasone
Volume: 2.0cc
Dose mA x min: 60
Current: 2.0
Skin Condition Post-Treatment: no blistering, only mild redness
Total Minutes: 31

Intervention Comments: Pt reports a burning after the txm but not necessarily an increase in pain

Goals:
Short Term:
1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term:
1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: Cont with POC 3 x wk

Total UNTIMED Code Minutes:
Total TIMED Code Minutes: 31
Total Treatment Minutes: 31

Author: Rebecca Smith, COTA/L 12/19/2018 11:52

Electronically signed by Smith, Rebecca, COTA/L at 12/19/2018 11:52 AM EST
Office Visit Wagner, James, OT Right elbow pain (Primary Dx)

SAYRE
12/17/2018

Progress Notes - Wagner, James, OT - 12/17/2018 12:30 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 12/17/2018

Referring Physician: Michael Gorsline

Subjective Comments: " It seems no matter what I do the pain doesnt go away. I found I have cysts on my ovaries."

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1230
Time Out: 0115

Visit Count: 3

Pain at the START of Treatment: 5/10("It hurts all the time.")
Pain at the END of Treatment:

Precautions: Allergies(Allerg ic to tape/adhesive)

Iontophoresis (97033)
Body Area: Right elbow
Medication Used: Dexamethasone
Volume: 2.0cc
Dose mA x min: 80
Current: 2.5
Total Minutes: 34

Intervention Comments: Decided to move to iontophoresis with dexamethasone for the anti-inflammatory properties. She will continue to use orthosis PRN.

Goals:
Short Term:
1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term:
1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: See above

Total UNTIMED Code Minutes: 0
Total TIMED Code Minutes: 34
Total Treatment Minutes: 34

Author: James Wagner, OT 12/17/2018 13:07

Electronically signed by Wagner, James, OT at 12/17/2018 1:14 PM EST

Therapy Plan of Care - Wagner, James, OT - 12/17/2018 12:30 PM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Plan of Care
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Referring Physician: Michael Gorsline

Plan of Care Start Date: 12/17/18

Plan of Care Expiration Date: 3/17/19

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female.

Interventions/PI an: Initiate use of iontophoresis with dexamethasone for right lateral elbow pain due to constant pain which impairs occupational performance. (2 cc's @ 80 ma/min) right lateral elbow. If this has not improved symptoms in 2-3 weeks we will D/C ionto.

Intervention Comments: Intervention Comments: The following interventions may be used in OT for treatment of patient's condition: Therapeutic Activity 97530; Infrared 97026; Self Care 97535; Paraffin 97018; Manual **Therapy** 97140; OT R-Evaluation; Neuromuscular Re-Education 97112; Ultrasound 97035; Fluido **Therapy** 97022; Therapeutic Exercise 97110; E-Stim 97032; Vasopneumatic Device 97016; and any orthotic devices as indicated.

Frequency of Treatment: 2-3 times per week

Duration of Treatment: 3 months

Patient concurs with established treatment and goals.

I certify the need for these services furnished under this plan Occupational **Therapy** treatment while under my care.

Gorsline, Michael, PA-C
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: James Wagner, OT 12/17/2018 13:10

Electronically signed by Suarez, Paul, MD at 01/10/2019 12:37 PM EST
Telephone Friend, Kelly, RN

SAYRE
12/17/2018

Telephone Encounter - Friend, Kelly, FNP - 12/17/2018 1:49 PM EST

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 12/17/2018

Patient contacted office - feels she has anal fissure, painful BM - has used REctiv in past, would like another prescription. Will order.

Author: Kelly Friend, FNP 12/17/2018 13:49

Electronically signed by Friend, Kelly, FNP at 12/17/2018 1:51 PM EST

Date	Type	Specialty	Care Team	Description
12/13/2018	Hospital Admission	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 437 of 1112	Robert B. B2F	PAGE 109 OF 309 12/13/2018
11/21/2018	Office Visit		Braslow, Matthew Lim, DO	Outpatient Acute URI (Primary Dx)

SAYRE
11/21/2018

Progress Notes - Braslow, Matthew Lim, DO - 11/21/2018 10:00 AM EST

Formatting of this note might be different from the original.

Sayre Family Medicine - The Guthrie Clinic
One Guthrie Square
Sayre, PA 18840
Phone: 570-887-2239 Fax: 570-887-3285

Progress Note

Assessments & Plans:

Jennifer Lyn Brown is a 42-y.o. female who was seen today for the following problems:

Problem List Items Addressed This Visit
None

Visit **Diagnoses**

Acute URI - Primary
Relevant Medications
saline (OCEAN) nasal spray 0.65 %
fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension
benzonatate (TESSALON PERLES) 100 MG Oral Cap

Acute URI

- Pt presenting with a relatively short course of non-specific URI symptoms at this time.
- No Centor criteria definitively met, reassuring at this time to not be bacterial strep
- Discussed usual etiology and expected **prognosis** of condition, including the possibility of symptoms getting worse before getting better.
- Advised to maintain fluid intake and rest as practicable.
- Advised "behind the counter" Mucinex.
- Symptomatic treatment and supportive measures.
- Can return to clinic should symptoms worsen over time or fail to improve.

No Follow-up on file.

Subjective:

HPI:

Pt of Dr Gillan presenting to my clinic with a main concern for URI symptoms that began 3 days ago.

States the symptoms are mainly a runny nose, sniffles, cough, congestion, facial stuffiness. Possible low grade fever, unknown temp, but has been feeling hot and cold. Denies general body aches, they are mainly in her head. Has had issues trying to breathe through nose. Notes symptoms are worse in the AM. Has no swallowing issues. Has been pushing fluids, but little eating.

Notes father was in the hospital with pneumonia recently, and that she works in the hospital so she's always around some sick contacts. Tried OTC mucinex, nyquil last night. Notes it helped her get to sleep.

Patient's medications, allergies, past medical, surgical, social and family histories were reviewed and updated as

Review of Systems:

Review of Systems

Constitutional: Positive for activity change. Negative for fatigue and fever.

HENT: Positive for congestion, postnasal drip, sinus pain, sinus pressure and sore throat. Negative for trouble swallowing.

Eyes: Negative for visual disturbance.

Respiratory: Positive for cough. Negative for chest tightness and shortness of breath.

Cardiovascular: Negative for chest pain.

Gastrointestinal : Negative for abdominal pain, nausea and vomiting.

Musculoskeletal: Negative for arthralgias, **gait** problem, neck pain and neck stiffness.

Neurological: Negative for dizziness and headaches.

Psychiatric/Beha vioral: Negative.

Objective:

BP 130/86 (BP Location: Right arm, Patient Position: Sitting) | Pulse 80 | Temp 99.2 °F (37.3 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 285 lb 9.6 oz (129.5 kg) | SpO2 98% Comment: room air | BMI 39.83 kg/m²

Physical Exam

Constitutional: She is oriented to person, place, and time. Vital signs are normal. She appears well-developed and well-nourished. She is active and cooperative. She does not appear ill. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: Hearing, tympanic membrane and external ear normal.

Left Ear: Hearing, tympanic membrane and external ear normal.

Nose: Rhinorrhea present. Right sinus exhibits maxillary sinus tenderness and frontal sinus tenderness. Left sinus exhibits maxillary sinus tenderness and frontal sinus tenderness.

Mouth/Throat: Uvula is midline, oropharynx is clear and moist and mucous membranes are normal. No oropharyngeal exudate, posterior oropharyngeal edema or posterior oropharyngeal erythema.

- Nasal turbinates edematous to approximately 50% occlusion of the airway bilat.

Eyes: Conjunctivae, EOM and lids are normal. Right pupil is round. Left pupil is round. Pupils are equal.

Neck: Normal range of motion.

Cardiovascular: Normal rate, regular rhythm, S1 normal, S2 normal and normal heart sounds. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no decreased breath sounds. She has no wheezes. She has no rhonchi. She has no rales.

Abdominal: Soft. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema.

Lymphadenopathy:

Head (right side): No submental, no submandibular, no preauricular and no posterior auricular adenopathy present.

Head (left side): No submental, no submandibular, no preauricular and no posterior auricular adenopathy present.

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She has normal strength. **Gait** normal.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: She has a normal mood and affect. Her speech is normal and behavior is normal. Judgment and thought content normal. Cognition and memory are normal.

Nursing note and vitals reviewed.

Neurologic Exam

Mental Status

Oriented to person, place, and time.

Speech: speech is normal

Cranial Nerves

CN III, IV, VI

Extraocular motions are normal.

Pupils: equal

Motor Exam

For ease of review, Assessments & Plans have been moved to the top of the note.

Patient seen and discussed with Dr. Gillan, who agreed with this assessment and plan.

Matt Braslow, DO
Family Medicine, PGY-2
11/21/2018

Electronically signed by Braslow, Matthew Lim, DO at 11/23/2018 11:20 PM EST

Progress Notes - Gillan, Michael F, DO - 11/21/2018 10:00 AM EST

Guthrie Clinic/RPH Supervising DO Documentation

Date of Service: 11/21/2018 B#: 340616

I discussed the patient with the resident. I agree with the assessment diagnostic and treatment plan as documented in the resident's note.

Michael F Gillan, DO
Supervising Physician
Department of Family Medicine

Electronically signed by Gillan, Michael F, DO at 11/23/2018 11:20 PM EST

Nursing Note - Woodruff, Shannon, LPN - 11/21/2018 10:00 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 11/21/2018

Chief Complaint

Patient presents with

- URI

started sunday x 3 days. cough, sore throat, post nasal drip, bilat ears full, non productive cough.

- Sinus Problem

taking mucinex etc. has been off all week.

Author: Shannon Woodruff, LPN 11/21/2018 10:10

Electronically signed by Woodruff, Shannon, LPN at 11/21/2018 10:34 AM EST

11/15/2018	Office Visit	Georgetson, Michael J, MD FACG	Crohn's disease of small intestine with other complication (HCC) (Primary Dx); Fatigue, unspecified type
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<p>SAYRE</p> <p>11/15/2018</p>
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Progress Notes - Georgetson, Michael J, MD FACG - 11/15/2018 9:00 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 11/15/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

A 42-year-old female presents for a follow up. Pt states that she had not see any improvement and she is tired a lot and some abdominal pain.

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female who presents for follow-up of Crohn's disease. She has recently started Stelara after having previously been on anti TNF **therapy** and having a dx of drug induced Lupus

She has been having minimal GI symptoms since her first Stelara infusion earlier this week but has had abd pain in the lower bilateral quadrants.

No diarrhea. No bleeding

No other GI complaints

However marked fatigue

Recent labs indicated no significant cbc anomalies or chem anomalies to explain this

Overall felt better on prednisone and is concerned that she may need to go back on for a short course

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- diclofenac (VOLTAREN) 1 % Transdermal Gel 2 g by Topical route FOUR TIMES DAILY.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- predniSONE (DELTASONE) 10 MG Oral Tab Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-administered medications for this visit.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

PHYSICAL EXAMINATION:

VITALS: BP 124/78 (BP Location: Left arm, Patient Position: Sitting) | Pulse 79 | Resp 16 | Ht 5' 11" (1.803 m) | Wt 269 lb 8 oz (122.2 kg) | SpO2 98% | BMI 37.59 kg/m² Body mass index is 37.59 kg/m².

GENERAL: alert, oriented, no acute distress.

LUNGS: clear to auscultation bilaterally.

HEART: regular rhythm, no murmurs, no gallops, no rubs.

ABDOMEN: general exam: soft, non-tender, non-distended, without masses or organomegaly, normal active bowel sounds, Murphy's sign negative.

IMPRESSION:

- ICD-9-CM ICD-10-CM
1. Crohn's disease of small intestine with other complication (HCC) 555.0 K50.018
 2. Fatigue, unspecified type 780.79 R53.83

Plan

PLAN:

Continue the Stelara per protocol

Prednisone 30 mg per day x 10 days, wean by 2.5 mg every 10 day

Report status at least weekly

Follow up: Schedule follow-up here as needed if symptoms worsen.

Otherwise as above.

Author: Michael J Georgetson, MD FACG 11/15/2018 09:46

Electronically signed by Georgetson, Michael J, MD FACG at 11/15/2018 10:45 AM EST

Nursing Note - Colton, Bobbe, LPN - 11/15/2018 9:00 AM EST

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 11/15/2018

Chief Complaint

Patient presents with

- Follow Up

A 42vyer ole female presents for a follow up. Pt states that she had not see nany improvement and she is tired a lot and some abdominal pain.

Author: Bobbe Colton, LPN 11/15/2018 09:14

Electronically signed by Colton, Bobbe, LPN at 11/15/2018 9:17 AM EST

11/14/2018	Telephone	Shaw, Beth, RN	Other
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SAYRE 11/14/2018

Telephone Encounter - Shaw, Beth, RN - 11/14/2018 1:50 PM EST

Status report.... Patient called stating she is feeling awful. Extra tired, stomach hurts. Stelara Infusion started on 11/12/18. Patient overdue for office visit with GI provider, she will have scheduler arrange this.

Per patient - "It's been all I can do to function lately? I go home from work and go right to the couch. I don't get anything done at night. Jonathan has been doing things around the house because I can't. I'm having a hard time concentrating and remembering- I feel awful. I keep wishing I had a couple days to recuperate or just stay in bed. The tiredness has been ongoing though for the last few weeks and now it seems worse. I've had a slight stomach ache also since the infusion. I can eat, but my stomach just aches".

Electronically signed by Shaw, Beth, RN at 11/14/2018 1:56 PM EST

Telephone Encounter - Georgetson, Michael J, MD FACG - 11/14/2018 4:08 PM EST

Noted
appt tomorrow

Electronically signed by Georgetson, Michael J, MD FACG at 11/14/2018 4:08 PM EST

11/12/2018 Hospital Encounter Outpatient

Robert Packer Hospital

11/12/2018

Nursing Progress - Lee, Paula, RN - 11/12/2018 12:48 PM EST

Formatting of this note might be different from the original.

11/12/18 1240
Peripheral IV: Right Forearm
Placement Date/Time: 11/12/18 1239 Orientation: Right Location: Forearm Cath size: 24 Gauge # attempts: 2
Status: Blood return;Capped
Site **assessment**: No signs/symptoms of infection
Drsng status assess: Transparent dressing;Clean, dry, and intact
Drsng change/reinforce : New appliance

Patient arrived to unit ambulating and accompanied for initiation of Stelara infusion. IV inserted, patient felt lightheaded and dizzy (stated that this typically happens with IV insertion), BP dropped to 74/43- chair reclined back to lowest position provided with fluids, legs elevated with pillows. BP elevated to 81/52 patient stated she felt much better no longer dizzy.

Prior to infusion BP rechecked and 114/60, patient remain reclined during infusion. Provided with written patient education per Lexicomp for medication and advised on adverse side effects to report during infusion as well as to provider if they should occur qat home such as signs of allergic reaction or infection.

Infusion tolerated without adverse side effects. Post infusion IV removed and patient d/c from unit same as upon arrival.

Electronically signed by Lee, Paula, RN at 11/12/2018 1:08 PM EST

11/08/2018 Hospital Encounter

Robert Packer Hospital

11/08/2018

Outpatient
Right elbow pain (Primary Dx)

11/07/2018 Office Visit Wagner, James, OT

SAYRE

11/07/2018

Progress Notes - Wagner, James, OT - 11/07/2018 11:30 AM EST

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown

Referring Physician: Michael Gorsline

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Right elbow pain 719.42 M25.521

Subjective Comments: " I had my **EMG** and he said there was no nerve damage. I wore that splint at night to keep my elbow straight and it was awful."

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1125

Time Out: 1200

Visit Count: 2

Pain at the START of Treatment: 3/10

Pain at the END of Treatment: 3/10

New Orthosis

Type of Orthosis: Wrist control orthosis

L-Code: L3905 - PR WHO w/ Nontorsion Jnt(s) CF

Reason for Orthosis: Reduce Pain

Wearing Schedule: During activity;Remove daily with assistance to check skin or wound

Total Minutes: 20

Intervention Comments: Pt. Reports no relief from nocturnal orthotic for elbow and ulnar nerve symptoms. Pain continues to be primary concern however may be related to other medical history at present time. We are attempting to conservatively decrease her pain. I chose to use a different orthosis to decrease elbow pain.

Goals:

Short Term:

- 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks.
- 2) Increase painfree grip 5 lbs in right hand 2-3 weeks.
- 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term:

- 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Plan: F/U in 2-3 weeks using both orthotics PRN for pain control and heat/ice PRN.

Total UNTIMED Code Minutes: 20

Total TIMED Code Minutes: 0

Total Treatment Minutes: 20

Author: James Wagner, OT 11/7/2018 12:09

Electronically signed by Wagner, James, OT at 11/07/2018 12:14 PM EST

Scan Only Historical, Provider

Encounter

Scan Only Historical, Provider

Encounter

Hospital Encounter

Outpatient

Robert Packer Hospital

11/02/2018

439

Progress Notes - Thomas, Lura - 11/02/2018 1:36 PM EDT

Patient: Jennifer Lyn Brown
 MRN: 340616
 Sex: female
 Date of birth: 10/26/1976

 Handedness: Right
 Diabetic: Patient is not diabetic

Date of test: 11/2/2018

Technologist's Notes:

Technician: Lura Thomas

Electronically signed by Thomas, Lura at 11/02/2018 1:36 PM EDT
 11/02/2018 Hospital Encounter Fritzen, Michael, PT Repeat Series

Robert Packer Hospital

11/02/2018

Progress Notes - Fritzen, Michael, PT - 11/02/2018 10:39 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Physical **Therapy** Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 11

Referring Physician: Michael Gorsline

Primary **Diagnosis:**
 ICD-9-CM ICD-10-CM
 1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1035

Time Out: 1058

Total Session Minutes: 23

Pain at Start of Care: 0/10
 Walking 1/10

Pain at End of Care: 0/10

Subjective Comments:
 Got new shoes
 1st step better, No barefoot

Interventions:

Therapeutic Exercises (97110)
Total Minutes (all Therapeutic Exercise): 8

Manual **Therapy** (97140)
Soft Tissue Mobilization Details: L Plantarfascia: US 1.0 MHZ continous 1.2 watt/cm2 5:00 and Graston #4 sweeps
PROM: Plantarfascia stretches
Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm2 L plantarfascia with stretch
Total Minutes (All Manual **Therapy**): 15

Assessment: Patient demonstrates good progress pain intermittent and only 1/10 walking. She is IND with pt education and HEP. Discussed tx plan see in 2 wks. Patient also reports ongoing difficulty in pain walking.

Plan for Next Visit: reassess

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 23
Total Treatment Minutes: 23

Author: Michael Fritzen, PT 11/2/2018 10:57

Electronically signed by Fritzen, Michael, PT at 11/02/2018 10:58 AM EDT
Office Visit Wagner, James, OT

Right elbow pain (Primary Dx);
Right tennis elbow

SAYRE
11/01/2018

Progress Notes - Wagner, James, OT - 11/01/2018 12:30 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Evaluation
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 11/1/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521
2. Right tennis elbow 726.32 M77.11

Subjective Comments: " It hurts."

Prior Functional Status: Independent with no pain or functional limitation

Visual Inspection: Benign Inspection

Pain at Rest: 3/10, c/o nocturnal resting pain as well over dorsal forearm and over extensor wad/supinator.

Pain with Activity: 6/10

Location of Pain: (Dorsal forearm proximal)

Exacerbating Factors: Lifting; Pushing; Pulling; Repetitive Grip

Relieving Factors: Medication; Rest

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand therapy.

Current Outpatient Prescriptions:

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses., Disp: 12 mL, Rfl: 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- diclofenac (VOLTAREN) 1 % Transdermal Gel, 2 g by Topical route FOUR TIMES DAILY., Disp: 1 Tube, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting), Disp: 1 Each, Rfl: 3
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit, INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS, Disp: 4 Each, Rfl: 11
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate, Disp: 100 Each, Rfl: 1
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly, Disp: 100 Each, Rfl: 0
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 84 Tab, Rfl: 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution, Inject 1 mL beneath the skin EVERY SATURDAY., Disp: 12 mL, Rfl: 1
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- predniSONE (DELTASONE) 10 MG Oral Tab, Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop (Patient taking differently: 20 mg. Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop), Disp: 30 Tab, Rfl: 0
- predniSONE (DELTASONE) 10 MG Oral Tab, 10 mg daily x 1 week, then 5 mg daily., Disp: 30 Tab, Rfl: 0
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks., Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS., Disp: 90 Cap, Rfl: 0
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 0

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013

- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016

Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/2/2017

Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/11/2018

Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- COLONOSCOPY DIAGNOSTIC

- EGD 2002

- EGD N/A 8/13/2014

Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;

- EGD N/A 6/24/2016

Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD N/A 6/2/2017

Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD N/A 6/11/2018

Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- EGD (GUTHRIE / NON GUTHRIE)

- LAPAROSCOPIC CHOLECYSTECTOMY 2013

with liver **biopsy**

- PR CLOSED RX TARSAL FX,EACH

- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014

for obesity - Dr. Alley - RPH

- PR REMOVAL GALLBLADDER

- TONSILLECTOMY 11/26/07

Measurement Data:

Edema:None noted

Hand Dexterity: No FMC deficits in right hand

Strength Testing:

1-3 Trial Testing

R - Grip #1: 30.3lbs (Pain with gripping), Provocative position (elbow extension, forearm pronation and wrist extension produced increased pain in same location with decreased grip to 10 lbs)

L - Grip #1: 56.3lbs

Sensation: C/O intermittent ulnar nerve paresthesia in right hand D4-D5 mostly at night. She sleeps with arm extended mostly resting on a pillow.

- tinels at cubital Tunnel, no report of radicular symptoms in right UE, + elbow flexion test at 25 seconds in ulnar dermantome.

Quick Dash:

Quick Dash

Open a tight or new jar: Moderate Difficulty

Do heavy Household chores (e.g. wash walls, floors): Moderate Difficulty

Carry a shopping bag or briefcase: Moderate Difficulty

Wash your back: No Difficulty

Use a knife to cut food: No Difficulty

Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, hammering, tennis, etc.): Severe Difficulty

During the past week, to what extent has your arm, shoulder, or hand problem interefered with your normal social activities with family, friends, neighbors, or groups?: Moderately

During the past week, were you limited in your work or other daily activities as a result of your arm, shoulder, or hand problem?: Moderately Limited

Rate the severity of the following symptoms in the last week: Arm, shoulder, or hand pain: Severe

Rate the severity of the following symptoms in the last week: Tingling (pins and needles) in your arm, shoulder, or hand: Moderate

During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?: Severe Difficulty

QuickDASH Score: 47.73

Special Tests:++ pain with palpation of lateral epicondyle, + tenderness with palpation over supinator, + middle finger extension test at LE, + ECRB/L pain with MMT at LE, + pain at supinator with resisted supination and elbow extended.

Differential diagnosis: Lateral epicondylitis vs radial tunnel vs cubital tunnel.

Impairment Observations: 42 y/o right handed female who presents with right lateral elbow pain and ulnar nerve paresthesia which impairs occupational performance.

Rehabilitative Prognosis: Good

Goals:

Short Term: 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks. 2) Increase painfree grip 5 lbs in right hand 2-3 weeks. 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Long Term: 1) Pt. will be able to sleep t/out the night without pain at time of D/C.

Interventions/PI an: Pt. Will be having a left shoulder scope in February 2019. Pt. Will benefit from iontophoresis with dexamethasone (2 sites over LE and supinator). After pain is controlled move to more soft tissue work. Issue pilo-splint for cubital tunnel symptoms and fabricate a wrist control orthosis for lateral elbow pain.

Intervention Comments: The following interventions may be used in OT for treatment of patient's condition: Therapeutic Activity 97530; Infrared 97026; Self Care 97535; Paraffin 97018; Manual Therapy 97140; OT R-Evaluation; Neuromuscular Re-Education 97112; Ultrasound 97035; Fluido Therapy 97022; Therapeutic Exercise 97110; E-Stim 97032; Vasopneumatic Device 97016; and any orthotic devices as indicated. Iontophoresis with dexamethasone for right lateral elbow pain.

Was Occupational Therapy treatment performed at this visit? Yes

New Orthosis

Type of Orthosis: 215-SPH006 Orthotic Tunnel
L-Code: L3762 - PR EO Rigid w/o Joints Pre OTS
Reason for Orthosis: (Reduce nocturnal ulnar paresthesia)
Wearing Schedule: At night
Total Minutes: 10

Frequency of Treatment: 1-2 times a week

Duration of Treatment: 3 months

Patient concurs with established treatment and goals.

Total Timed Code Minutes: 60 (50 min evaluation , 10 min orthosis)
Total Treatment Minutes: 60

Author: James Wagner, OT 11/1/2018 13:05

Electronically signed by Wagner, James, OT at 11/01/2018 1:11 PM EDT

Therapy Plan of Care - Wagner, James, OT - 11/01/2018 12:30 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Plan of Care
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 11/1/2018

Referring Physician: Michael Gorsline

Plan of Care Start Date: 11/01/18

Plan of Care Expiration Date: 01/01/19

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Right elbow pain 719.42 M25.521
2. Right tennis elbow 726.32 M77.11

Subjective Comments: " It hurts."

Prior Functional Status: Independent with no pain or functional limitation

Rehabilitative **Prognosis**: Good

Systems Review/History of Current Problem: She is a 42-y.o.-year-old female. History of Current Problem: who reports slow insidious onset of dorsal proximal forearm pain which slowly progressed. She was seen in orthopedics and referred to OT/hand **therapy**.

Goals:

Short Term: 1) Decrease resting pain dorsal forearm/elbow to 2/10 in 2-3 weeks. 2) Increase painfree grip 5 lbs in right hand 2-3 weeks. 3) Decrease mechanical elbow pain to 4/10 2-3 weeks.

Impairment Observations: See evaluation

Intervention Comments: Intervention Comments: The following interventions may be used in OT for treatment of patient's condition: Therapeutic Activity 97530; Infrared 97026; Self Care 97535; Paraffin 97018; Manual **Therapy** 97140; OT R-Evaluation; Neuromuscular Re-Education 97112; Ultrasound 97035; Fluido **Therapy** 97022; Therapeutic Exercise 97110; E-Stim 97032; Vasopneumatic Device 97016; and any orthotic devices as indicated. Iontophoresis with dexamethasone right lateral elbow.

Frequency of Treatment: 1-2 times a week

Duration of Treatment: 3 months

Patient concurs with established treatment and goals.

I certify the need for these services furnished under this plan Occupational **Therapy** treatment while under my care.

Gorsline, Michael, PA-C
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: James Wagner, OT 11/1/2018 13:08

10/30/2018

Electronically signed by Gorsline, Michael, PA-C at 11/02/2018 9:14 AM EDT

Office Visit

Gorsline, Michael, PA-C

Right tennis elbow (Primary Dx);
Numbness and tingling of right arm

SAYRE

10/30/2018

Progress Notes

- Gorsline, Michael, PA-C - 10/30/2018 1:30 PM EDT

Formatting of this note might be different from the original.

Name: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 10/30/2018

Chief Complaint
Patient presents with
• Elbow Pain
right elbow pain down to fingers

SUBJECTIVE:
Jennifer Lyn Brown is a 42-y.o. female who presents to the office today with a complaint of right elbow pain that refers to her right 5th finger. She reports numbness/tinglin g. She also reports lateral sided right elbow pain. She has had symptoms for 3-4 weeks. She has tried some ibuprofen which hasn't helped. She is right handed. Symptoms are worse with use.

Past Medical History:
Diagnosis Date
• Anal fissure 1/2013
• **Anxiety**
• Attention deficit
• Back ache 3/18/2014
• Calcaneal spur 6/30/2008
• Cherry angioma 8/9/2016
• Cholecystitis
• CHRONIC SINUSITIS NOS 5/23/2005
CT 2005
• Crohn disease (HCC)

- Depression 10/2/2004
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
- Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2013
- with liver **biopsy**
- PR CLOSED RX TARSAL FX,EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
- for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
- TONSILLECTOMY 11/26/07

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father

- Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 452 of 1112
- Genetic Father
 - Marfan syndrome
 - Heart Father
 - ?Marfan's Syndrome
 - Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle
 - Aortic Dissection, Marfan's Syndrome
 - Heart Disease Paternal Uncle
 - Diabetes Maternal Grandfather
 - Thyroid Disease Maternal Grandfather
 - Macular Degeneration Paternal Grandmother
 - Psychiatry Maternal Aunt
 - ADHD
 - Genetic Maternal Aunt
 - Marfan syndrome
 - Psychiatry Other
 - ADHD
 - **Cancer** Paternal Grandfather
 - Glaucoma No family history
 - Blindness No family history
 - Other Eye Problems No family history
 - Anesth Problems No family history

Social History

Social History Main Topics

- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
 - calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
 - Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
 - cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
 - cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
 - diclofenac (VOLTAREN) 1 % Transdermal Gel 2 g by Topical route FOUR TIMES DAILY.
 - EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
 - fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
 - HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
 - Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 448 S.
- Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly

- Case 6:21-cv-06189-LGS Document 18 Filed 08/27/23 Page 458 of 1112
- EXHIBIT NO. B2F**
PAGE: 125 OF 309
- levonorgestrel (Mirena) Intrauterine System (IUS) Insert 1 IUS by vagina DAILY.
 - lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
 - loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
 - methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
 - ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
 - pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
 - prednisONE (DELTAONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop (Patient taking differently: 20 mg. Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop)
 - prednisONE (DELTAONE) 10 MG Oral Tab 10 mg daily x 1 week, then 5 mg daily.
 - Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
 - Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
 - Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
 - venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
 - venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-administered medications for this visit.

Review of Systems:

Nursing Notes:

Abbott, Courtney, ST 10/30/2018 1:41 PM Signed

NAME: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 10/30/2018

CONSTITUTIONAL: negative.

HEENT: negative.

EYES: negative.

RESPIRATORY: negative.

CARDIOVASCULAR: negative.

GASTROINTESTINAL : negative.

GENITOURINARY: negative.

INTEGUMENT/BREAST: negative.

HEMATOLOGIC/LYMPHATIC: negative.

MUSCULOSKELETAL: Negative except right elbow to finger tips pain, doesn't think its related to previous thumb pain; pain level 0-10= 3.

NEUROLOGICAL: negative.

BEHAVIORAL/PSYCH : negative.

ENDOCRINE: Negative.

ALLERGIC/IMMUNOLOGIC: Negative.

Body mass index is 41.14 kg/m².

AUTHOR: Courtney Abbott, ST 10/30/2018 13:38

OBJECTIVE:

Physical Exam:

Ht 5' 11" (1.803 m) Wt 295 lb (133.8 kg) BMI 41.14 kg/m²

Right hand/wrist/elbow without swelling, ecchymosis or gross deformity. Good alignment. No laxity of elbow or wrist. Point tender over the lateral epicondyle. Sore with resisted wrist extension and resisted pronation/supination. Sore with resisted 3rd digit extension.
+tinel's at elbow.

ASSESSMENT:

ICD-9-CM ICD-10-CM

1. Right tennis elbow 726.32 M77.11 REFER TO OCCUPATIONAL **THERAPY** / REHAB
2. Numbness and tingling of right arm 782.0 R20.0 **EMG/NCV**
R20.2

PLAN:

Treatment plan for left wrist/ulnar nerve disease. Document rest, ice, elevation and anti-inflammatory medications, bracing occupational therapy.

Will obtain an **EMG** to rule out an ulnar neuropathy.

Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated.

Author: Michael Gorsline, PA-C, ATC 10/30/2018 13:48

Electronically signed by Gorsline, Michael, PA-C at 10/30/2018 1:51 PM EDT

Nursing Note - Abbott, Courtney, ST - 10/30/2018 1:30 PM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 10/30/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAS T: negative.
HEMATOLOGIC/LYMP HATIC: negative.
MUSCULOSKELETAL: Negative except right elbow to finger tips pain, doesn't think its related to previous thumb pain; pain level 0-10= 3.
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: Negative.
ALLERGIC/IMMUNOL OGIC: Negative.

Body mass index is 41.14 kg/m².

AUTHOR: Courtney Abbott, ST 10/30/2018 13:38

Electronically signed by Abbott, Courtney, ST at 10/30/2018 1:41 PM EDT

10/30/2018

Telephone

Marshall, Pamela, LPN

Insurance/Prior Authorization (Stelara)

SAYRE

10/30/2018

Telephone Encounter - Marshall, Pamela, LPN - 10/30/2018 9:32 AM EDT

Prior authorization for Stelara faxed to Alliance 844-394-4200.

Electronically signed by Marshall, Pamela, LPN at 10/30/2018 9:32 AM EDT

Telephone Encounter - Marshall, Pamela, LPN - 11/05/2018 8:03 AM EST

Stelara IV X 1 has been approved thru Alliance case # 3562714 req-4847814. Approved from 11/1/18-12/30/18 , referral and approval sent to infusion center.

Electronically signed by Marshall, Pamela, LPN at 11/05/2018 8:05 AM EST

Telephone Encounter - Marshall, Pamela, LPN - 11/05/2018 3:48 PM EST

Stelara injection is approved from 11/5/18-11/5/19, PA # 50253036 faxing script and approval to the clinic pharmacy.
Pamela Marshall, LPN

10/26/2018

Hospital Encounter

Fritzen, Michael, PT

Robert Packer Hospital

10/26/2018

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EXHIBIT NO. B2F

PAGE: 127 OF 309

Progress Notes - Fritzen, Michael, PT - 10/26/2018 11:35 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic

Treatment Note

Outpatient Physical **Therapy** Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL **THERAPY**

1 Guthrie Square

Sayre PA 18840-1625

570-887-4801

570-888-6666

Treatment Number: 10

Referring Physician: Michael Gorsline

Primary **Diagnosis**:

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1134

Time Out: 1153

Total Session Minutes: 19

Pain at Start of Care: 0/10

Walk 2/10

Pain at End of Care: 0/10

Subjective Comments: 1st step pain better

Overall better, No pain R 100% better

Interventions:

Therapeutic Exercises (97110)

Number of Exercises?: 4

Total Minutes (all Therapeutic Exercise): 5

Exercise #1

Exercise Name: Plantarfascia stretch

Details: cued to bring meta head P-A also

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual **Therapy** (97140)

Soft Tissue Mobilization Details: L Plantarfascia: US 1.0 MHZ continous 1.2 watt/cm2 5:00 and Graston #4 sweeps

PROM: Plantarfascia stretches

Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm2 L plantarfascia with stretch

Assessment: Patient demonstrates better progress > L foot pain decreasing with walking. She is IND with pt education and HEP. Patient also reports ongoing difficulty in Pain walking. See next wk continue soft tissue > if better than decrease to 1/ 2 wks.

- Short Goals: (2-4 wks)
- 1) IND education -- MET
 - 2) IND 1st step pain control -- MET
 - 3) decrease pain 25% end of day -- MET
- Long TErM Goals: (2-3 months)
- 1) Decrease pain 50% end of day -- MET
 - 2) Intermittent pain walking -- MET
 - 3) increase functional status 24 points per FOTO survey -- PROGRESSING
 - 4) resume walking dog pain limited

Plan for Next Visit: See POC

Total UNTIMED Code Treatment Minutes:
 Total TIMED Code Treatment Minutes: 20
 Total Treatment Minutes: 20

Author: Michael Fritzen, PT 10/26/2018 11:53

Electronically signed by Fritzen, Michael, PT at 10/26/2018 12:01 PM EDT	
10/26/2018 Telephone	Shaw, Beth, RN Orders (lab And Procedure)

SAYRE
10/26/2018

Telephone Encounter - Shaw, Beth, RN - 10/26/2018 11:47 AM EDT

Orders printed for Stelara IV infusion x one dose and Stelara injections SQ every 8 weeks. Dr.Georgetson to sign and give to Pam Marshall to complete Prior Authorization process, then fax to Infusion Center and patient's Pharmacy.

Electronically signed by Shaw, Beth, RN at 10/26/2018 11:50 AM EDT

Telephone Encounter - Marshall, Pamela, LPN - 10/26/2018 1:52 PM EDT

Prior authorization for Stelara was faxed to Highmark

Electronically signed by Marshall, Pamela, LPN at 10/26/2018 1:53 PM EDT	
10/24/2018 Office Visit	Freeman, James, MD
10/24/2018 Hospital Encounter	Fritzen, Michael, PT Repeat Series

Robert Packer Hospital
10/24/2018

Progress Notes - Fritzen, Michael, PT - 10/24/2018 11:38 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Physical **Therapy** Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801

Treatment Number: 9

Referring Physician: Michael Gorsline

Primary Diagnosis:

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1135

Time Out: 1200

Total Session Minutes: 25

Pain at Start of Care: 1/10

Walking 3/10 L foot

Pain at End of Care: 1/10

Subjective Comments: IND 1st step pain education < no pain

Wall stretch 3/day

R foot feels 100% better

Drug induced Lupus > seeing Rheumatology today

Interventions:

Educated on activity and pain, And ex bike for wt loss (can use guthrie gym)

Therapeutic Exercises (97110)

Number of Exercises?: 4

Total Minutes (all Therapeutic Exercise): 10

Exercise #1

Exercise Name: Plantarfascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual Therapy (97140)

Soft Tissue Mobilization Details: L Plantarfascia: US 1.0 MHZ continous 1.2 watt/cm2 5:00 and Graston #4 sweeps

PROM: Plantarfascia stretches

Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm2 L plantarfascia with stretch

Total Minutes (All Manual **Therapy**): 15

Assessment: Patient demonstrates better progress with pain. Her R foot 100% better, L progressing. She is IND with Pt education. Continue soft tissue > if better next tx then can decrease to 1/1-2 wks. Can use ex bike for wt loss until painfree than can restart walking program.

Plan for Next Visit: See above

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 25

Total Treatment Minutes: 25

Author: Michael Fritzen, PT 10/24/2018 12:01

Electronically signed by Fritzen, Michael, PT at 10/24/2018 12:03 PM EDT

Telephone

Shaw, Beth, RN

Medical Question

SAYRE
10/22/2018

Telephone Encounter - Shaw, Beth, RN - 10/22/2018 9:06 AM EDT

"Dr. Georgetson,
Good Morning. I know you are inpatient this week. I have a problem- Dr. Freeman and Dr. Rahman ran my blood work and it is showing Positive for Drug Induced Lupus. I asked Dr. Rahman how do they know if it is drug induced or regular Lupus and have not received a response yet? Dr. Freeman wanted me to discuss treatment options with GI. I was in bed all weekend long and I am dragging- My joints hurt, I have no energy, brain fog, etc., etc. Not sure if this is the humira causing this like the Remicaide did"?

Please review patient's concern above and advise. Thanks.

Electronically signed by Shaw, Beth, RN at 10/22/2018 9:10 AM EDT

Telephone Encounter - Georgetson, Michael J, MD FACG - 10/22/2018 9:15 AM EDT

I would stop the Humira
Follow instructions per Rheumatology
Will likely need therapy down the line but I would suggest moving away from the current class of meds

Electronically signed by Georgetson, Michael J, MD FACG at 10/22/2018 9:16 AM EDT

Telephone Encounter - Shaw, Beth, RN - 10/22/2018 9:52 AM EDT

Patient instructed to stop Humira and follow up with Dr.Freeman as scheduled on November 7, 2018.
Also instructed to schedule GI follow up to discuss new plan of care.
Patient questioning if she should continue Methotrexate. States no new instructions given per Rheumatology at this time.
Also questioning if GI f/u needs to be before or after Rheumatology visit?
Please advise, thanks.

Electronically signed by Shaw, Beth, RN at 10/22/2018 9:56 AM EDT

Telephone Encounter - Georgetson, Michael J, MD FACG - 10/22/2018 10:07 AM EDT

GI after
Continue the MTX
I will catch up with her in the office

Electronically signed by Georgetson, Michael J, MD FACG at 10/22/2018 10:07 AM EDT

Telephone Encounter - Shaw, Beth, RN - 10/22/2018 10:53 AM EDT

Patient instructed to continue Methotrexate and scheduled GI office f/u for after Rheumatology appointment. Patient verbalized understanding and agreement. She will also talk to Dr.Georgetson in the office in the meantime.

Electronically signed by Shaw, Beth, RN at 10/22/2018 10:55 AM EDT

Telephone Encounter - Shaw, Beth, RN - 10/25/2018 11:17 AM EDT

"I saw Dr. Freeman yesterday for the drug induced Lupus and RA. The visit was cut short, but Dr. Freeman said that probably either Stelera or Xeljanz may help. He wants something that is going to help both my Crohn's and RA. He asked me about how much Prednisone I am taking a day, I said 10 mg. He didn't change that, but I got thinking I am almost out of it. Dr. Georgetson actually ordered my last Prednisone, Dr. Freeman was just having me take it.

Can you let me know where to go from here? Thanks! Jen"

Electronically signed by Shaw, Beth, RN at 10/25/2018 11:18 AM EDT

Lets pre cert her for stellara
 Lets stay on the prednisone at 10 mg for one more week then try drop to 5 mg

Electronically signed by Georgetson, Michael J, MD FACG at 10/25/2018 1:40 PM EDT

Telephone Encounter - Shaw, Beth, RN - 10/25/2018 2:15 PM EDT

Patient informed of recommendations. She is requesting a refill on Prednisone. Stelara orders awaiting Dr.Georgetson's signature before prior authorization can be completed.
 Patient verbalized understanding and agreement to plan.
 Will await prior authorization process.

Electronically signed by Shaw, Beth, RN at 10/25/2018 2:50 PM EDT

Addendum Note - Shaw, Beth, RN - 10/25/2018 2:50 PM EDT

Addended by: SHAW, BETH on: 10/25/2018 02:50 PM

Modules accepted: Orders

Electronically signed by Shaw, Beth, RN at 10/25/2018 2:50 PM EDT

Addendum Note - Georgetson, Michael J, MD FACG - 10/25/2018 2:56 PM EDT

Addended by: GEORGETSON, MICHAEL J on: 10/25/2018 02:56 PM

Modules accepted: Orders

Electronically signed by Georgetson, Michael J, MD FACG at 10/25/2018 2:56 PM EDT

10/19/2018

Telephone

Desisti, Deborah

Lab Work Only

SAYRE

10/19/2018

Telephone Encounter - Desisti, Deborah - 10/19/2018 10:34 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 10/19/2018

Patient called regarding lab results staff message sent to dr. Freeman.

Author: Deborah Desisti 10/19/2018 10:36

Electronically signed by Desisti, Deborah at 10/19/2018 10:37 AM EDT

10/17/2018

Hospital Encounter

Abbott, Berniece, PTA

Repeat Series

Robert Packer Hospital

10/17/2018

Progress Notes - Abbott, Berniece, PTA - 10/17/2018 1:28 PM EDT

Formatting of this note might be different from the original.

Treatment Number: 8

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1315

Time Out: 1345

Total Session Minutes: 30

Pain at Start of Care: 0/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated doing better.

Interventions:
Cardiovascular Exercise (97110)
Number of Cardiovascular Exercise(s): 1
Time (minutes): 5

Cardiovascular Exercise 1
Equipment Used: Recumbent Bike
Purpose of Exercise: Functional Mobility
Intensity: (level 4)

Therapeutic Exercises (97110)
Number of Exercises?: 4
Total Minutes (all Therapeutic Exercise): 10

Exercise #1
Exercise Name: Plantarfascia stretch

Exercise #2
Exercise Name: Standing wall push calf stretch with inv

Exercise #3
Exercise Name: Band Walking
Reason for Exercise: Functional Mobility;Muscle Performance
Location/Body Area: Bilateral;LE
Sets/Reps: 3 ways 20'
Resistance: Red band

Exercise #4
Exercise Name: Toe Raises
Reason for Exercise: Functional Mobility;Muscle Performance
Location/Body Area: Bilateral;LE
Sets/Reps:X 30

Manual **Therapy** (97140)
Soft Tissue Mobilization: Manual Tissue Mobilization;IAS TM
Instrument-Assis ted Soft Tissue Mobilization: (Empahsis on left heel)
PROM: Plantarfascia stretches
Total Minutes (All Manual **Therapy**): 15

Comment:
Patient purchased BFO 5 orthotics

Assessment: Patient demonstrates Improvement with the purchase of the BFO 5 orthotics. Patient also reports being able to stand longer and walk further. Still having some problems when first standing, however working on this. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Plan for Next Visit: Continue to strengthen patient's plantar fascia with increased strengthening.

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 30
Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 10/17/2018 14:12

Electronically signed by Abbott, Berniece, PTA at 10/17/2018 2:18 PM EDT
Hospital Encounter Fritzen, Michael, PT

Repeat Series

Robert Packer Hospital 10/15/2018

Progress Notes - Fritzen, Michael, PT - 10/15/2018 12:04 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Progress Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-4801
570-888-6666

Treatment Number: 7

Referring Physician: Michael Gorsline

Primary **Diagnosis:**
ICD-9-CM ICD-10-CM
1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1200

Time Out: 1230

Total Session Minutes: 30

Pain at Start of Care: 0/10
Walking 3/10

Pain at End of Care: 0/10

Subjective Comments: Last night pain 3/10
1st step pain better
Not barefoot walking
Has not got orthotic
Calf 2-3/day
Ice bottle PRN
L foot pain worse than R

Interventions:

Therapeutic Exercises (97110)
 Number of Exercises?: 4
 Total Minutes (all Therapeutic Exercise): 15

Exercise #1
 Exercise Name: Plantarfascia stretch

Exercise #2
 Exercise Name: Standing wall push calf stretch with inv

Exercise #3
 Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4
 Exercise Name: Trialled BFO 5 orthotics > felt much better

Manual **Therapy** (97140)
 Soft Tissue Mobilization Details: B/L Plantarfascia: US 1.0 MHZ continous 1.2 watt/cm2 2:30 and Graston #4 sweeps
 PROM: Plantarfascia stretches
 Joint Mobilization: Posterior Talar glides B/L
 Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm2 B/L plantarfascia with stretch
 Total Minutes (All Manual **Therapy**): 15

Assessment: We evaluated Mrs. Brown in PT on 9/12/18 and have seen her 7 tx's, 2nd to B/L Plantarfascitis. She has been compliant with her PT services and is slowly progressing better. I feel she needs basic offshelf arch support BFO 5, to help decrease stress across plantarfascia 2nd to her wt. She will get today. Reviewed pt education she is IND with 1st step, and not increasing pain with walking program. Recommend her to perform ex bike for wt loss. Continue to see 1-2/wk until pain better than 1/1-2 wks till she is walking pain free.

Short Goals: (2-4 wks)
 1) IND education -- MET
 2) IND 1st step pain control -- MET
 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)
 1) Decrease pain 50% end of day -- PROGRESSING
 2) Intermittent pain walking
 3) increase functional status 24 points per FOTO survey -- PROGRESSING
 4) resume walking dog pain limited

Plan for Next Visit: Continue soft tissue

Total UNTIMED Code Treatment Minutes:
 Total TIMED Code Treatment Minutes: 30
 Total Treatment Minutes: 30

Author: Michael Fritzen, PT 10/15/2018 12:36

Electronically signed by Fritzen, Michael, PT at 10/15/2018 12:39 PM EDT
 10/11/2018 Hospital Encounter Abbott, Berniece, PTA Repeat Series

Robert Packer Hospital 10/11/2018
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Progress Notes - Abbott, Berniece, PTA - 10/11/2018 11:15 AM EDT

The Guthrie Clinic
Treatment Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-4801
570-888-6666

Treatment Number: 6

Referring Physician: Michael Gorsline

Primary **Diagnosis**:

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1110

Time Out: 1133

Total Session Minutes: 23

Pain at Start of Care: 4/10

Pain at End of Care: 2/10

Subjective Comments: Patient went on a vacation to the Pocono's and did a lot of walking, increasing the pain in her feet. She continues to be compliant with her HEP, except on her vacation.

Interventions:

Exercise #1

Exercise Name: Plantar fascia stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control

Location/Body Area: Bilateral;Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #3

Exercise Name: Heel/Toe raises

Reason for Exercise: Flexibility;Strengthening;Muscle Performance

Location/Body Area: Bilateral;Foot

Sets/Reps: (x 30)

Resistance: none

Manual **Therapy** (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 20%)

Total Minutes (All Manual **Therapy**): 15

Assessment: Patient having increased pain in her plantar fascia. She went on vacation walked a lot however did do her daily stretches and ice her feet. Patient did start her HEP as soon as she returned. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Plan for Next Visit: 2 months to work on plantar fasciitis, taping and sound for hearing properties

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 23

Total Treatment Minutes: 23

Author: Berniece Abbott, PTA 10/11/2018 12:13

Electronically signed by Abbott, Berniece, PTA at 10/11/2018 12:18 PM EDT

Lab

SAYRE

10/10/2018

Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC)

Repeat Series

10/03/2018 Hospital Encounter Abbott, Berniece, PTA

Robert Packer Hospital

10/03/2018

Progress Notes - Abbott, Berniece, PTA - 10/03/2018 12:43 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
 Treatment Note
 Outpatient Physical **Therapy** Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 5

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
 ICD-9-CM ICD-10-CM
 1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1230

Time Out: 1302

Total Session Minutes: 32

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated she will be getting her orthotics this weekend. She will have 5 days off. Patient stated her feet have been sore, but not painful

Interventions:

Therapeutic Exercises (97110)
 Number of Exercises?: 3
 Total Minutes (all Therapeutic Exercise): 10

Exercise #1

Exercise Name: Plantar fascial stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control

Location/Body Area: Bilateral;Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #3

Exercise Name: Heel/Toe raises

Reason for Exercise: Flexibility;Strengthening;Muscle Performance

Location/Body Area: Bilateral;Foot

Sets/Reps: (x 30)

Resistance: none

Manual **Therapy** (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 20%)

Total Minutes (All Manual **Therapy**): 20

Assessment: Patient demonstrates continued improvement with less pain in her feel and able to be on them more. Patient states she is compliant with her HEP. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Plan for Next Visit: Continue to strengthen and stretch involved musculatures.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 30

Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 10/3/2018 14:37

Electronically signed by Abbott, Berniece, PTA at 10/03/2018 2:40 PM EDT

09/27/2018

Hospital Encounter

Abbott, Berniece, PTA

Repeat Series

Robert Packer Hospital

09/27/2018

Progress Notes - Abbott, Berniece, PTA - 09/27/2018 3:49 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic

Treatment Note

Outpatient Physical **Therapy** Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL **THERAPY**

1 Guthrie Square

Sayre PA 18840-1625

570-887-4801

570-888-6666

Treatment Number: 4

Referring Physician: Michael Gorsline

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1035

Time Out: 1105

Total Session Minutes: 30

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient reports doing well. Pain reduction, only flares when she is on her feet a lot. Patient stated she will get OTC orthotics this weekend.

Interventions:

Therapeutic Exercises (97110)

Number of Exercises?: 4

Total Minutes (all Therapeutic Exercise): 10

Exercise #1

Exercise Name: Plantar fascia stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control

Location/Body Area: Bilateral;Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #4

Exercise Name: Toe lift, standing

Reason for Exercise: Strengthening;Neuromuscular Training;Pain Control

Sets/Reps: 3 X 30 sec each

Resistance: Body Weight

Details: At home perform in the shower

Manual **Therapy** (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 40%)

Total Minutes (All Manual **Therapy**): 20

Assessment: Patient demonstrates Compliance with HEP and has reduction in daily pain levels. If patient continues and gets OTC orthotic she may be ready for D/C. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Plan for Next Visit: Continue with strengthening LE.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 30

Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 9/27/2018 15:59

Electronically signed by Abbott, Berniece, PTA at 09/27/2018 4:12 PM EDT

Office Visit

Freeman, James, MD

Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (H462 primary Dx); Crohn's disease without complication, unspecified

09/26/2018

SAYRE**09/26/2018****Progress Notes** - Rahman, Hammad, MD - 09/26/2018 2:20 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 9/26/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female.

HPI

With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira later on humaira and methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Pt was seen last month for the follow up of RA and at that time she was having some joint inflammations and was given prednisone taper for 12 days. As soon as she finished her prednisone, she developed diarrhea, she called GI and also she has worsening fatigue and stiffness in the joint, so she was started on prednisone 20 mg by GI. She is on that dose for last 20 days.

Today she feels little better, her arthritis is slightly better as well as the nausea. About 3-4 days, she was not able to move her wrists. She says that she feels tired and lethargic all the time and it is worse than before. Mainly the inflammation and stiffness started in her fingers and then wrist and then the other hands fingers and wrist as well as the toes. She feels like her fingers are burning.

Her ESR has always been in the normal range. She has allergic to remicade in the past, had possible drug induced lupus.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea I reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension

- Morbidly obese (BMI)
 - Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Family History
 Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly

- levonorgestrel (Mirena) Intrauterine Device (IUD) Oral Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- [START ON 9/29/2018] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- predniSONE (DELTASONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop (Patient taking differently: 20 mg. Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop)
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-adminis tered medications for this visit.

- Allergies
- Allergen Reactions
- Bee Stings [Bee Sting] Swelling
 - Remicade [Infliximab] Rash
 - Tape: Silk Or Adhesive Rash

Social History

- Social History Main Topics
- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
- Birth control/ protection: Pill, Condom
- Comment: OCPs

- Other Topics Concern
- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Positive for malaise/fatigue. Negative for chills, diaphoresis, fever and weight loss.

HENT: Negative for congestion, ear discharge, ear pain, hearing loss, nosebleeds and tinnitus.

Eyes: Negative for blurred vision, double vision, photophobia and pain.

Respiratory: Negative for cough, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal : Negative for abdominal pain, constipation, diarrhea, heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency, hematuria and urgency.

Musculoskeletal: Positive for joint pain. Negative for back pain, falls, myalgias and neck pain.

Skin: Negative for rash.

Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, weakness and headaches.

Endo/Heme/Allerg ies: Does not bruise/bleed easily.

Psychiatric/Beha vioral: Negative for **depression** and memory loss.

Objective

PHYSICAL EXAM:

VITALS: BP 110/80 | Ht 5' 11" (1.803 m) | Wt 296 lb (134.3 kg) | BMI 41.28 kg/m² Body mass index is 41.28 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No

distress.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: Nose normal.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.
Neck: Normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.
Cardiovascular: Normal rate, regular rhythm and intact distal pulses.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: She exhibits no edema or deformity.
Right shoulder: Normal. She exhibits normal range of motion and no tenderness.
Left shoulder: Normal. She exhibits normal range of motion and no tenderness.
Right elbow: She exhibits normal range of motion and no swelling.
Left elbow: She exhibits normal range of motion and no swelling.
Right wrist: She exhibits normal range of motion and no tenderness.
Left wrist: She exhibits normal range of motion and no tenderness.
Right hand: She exhibits swelling. She exhibits normal range of motion, no tenderness, no bony tenderness and no laceration.
Left hand: She exhibits swelling. She exhibits normal range of motion, no tenderness and no bony tenderness.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert and oriented to person, place, and time. She has normal reflexes. No cranial nerve deficit. **Gait** normal. GCS score is 15.
Skin: Skin is warm and dry. She is not diaphoretic.
Psychiatric: Mood and affect normal.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC) 714.0 M05.79 ANTI NUCLEAR ANTIBODY
ANTI HISTONE ANTIBODY
2. Crohn's disease without complication, unspecified gastrointestinal tract location (HCC) 555.9 K50.90

Plan

Rheumatoid arthritis:

- Due to recent flares and taking prednisone for longer duration is risky, will change oral methotrexate to SQ methotrexate 25 mg for better absorption as she has Crohn disease as well.
- CDAI score around 20.
- if this does not help, we might have to change Humira.
- Will check ANA and anti-histone antibodies to see if she has reaction to Humira. Advised to go down to prednisone 10 mg and see.

Crohn disease:

- as per GI.

Follow up in 6 weeks.

Pt was seen and discussed with Dr. Freeman.

Author: Hammad Rahman, MD 9/27/2018 16:05

Electronically signed by Rahman, Hammad, MD at 09/27/2018 4:07 PM EDT

Progress Notes - Freeman, James, MD - 09/26/2018 2:20 PM EDT

I saw and evaluated the patient. Discussed with resident and agree with the resident's **findings** and plan as documented in

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 10/03/2018 1:38 PM EDT
Refill Jewell, Jan, RN

SAYRE
09/26/2018

Telephone Encounter - Jewell, Jan, RN - 09/26/2018 4:04 PM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Pending Prescriptions Disp Refills
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc 12 Each 0
Sig: Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 100 Each 0
Sig: Inject beneath the skin EVERY 7 DAYS. Use with methotrexate weekly

Electronically signed by Jewell, Jan, RN at 09/26/2018 4:07 PM EDT

Telephone Encounter - Jewell, Jan, RN - 09/27/2018 11:05 AM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Signed Prescriptions Disp Refills
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc 12 Each 0
Sig: Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
Authorizing Provider: FREEMAN, JAMES G
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 100 Each 0
Sig: Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
Authorizing Provider: FREEMAN, JAMES G
E-script done by provider..

Electronically signed by Jewell, Jan, RN at 09/27/2018 11:05 AM EDT
Hospital Encounter Abbott, Berniece, PTA Repeat Series

Robert Packer Hospital
09/25/2018

Progress Notes - Abbott, Berniece, PTA - 09/25/2018 1:06 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-4801
570-888-6666

Treatment Number: 3

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1206

Time Out: 1310

Total Session Minutes: 64

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated she feels the stretches and manual is working on reducing her pain. She will get inserts for her shoes on pay day.

Interventions:

Therapeutic Exercises (97110)

Number of Exercises?: 4

Total Minutes (all Therapeutic Exercise): 15

Exercise #1

Exercise Name: Plantarfascia stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control

Location/Body Area: Bilateral;Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking (Must move feet with circles, point toes,dorsiflex)

Reason for Exercise: Flexibility;Functional Mobility;Muscle Performance;Pain Control

Location/Body Area: Bilateral;Foot;Ankle

Sets/Reps: 6 X

Resistance: None

Details: (Promotes blood flow, reduces tearing)

Exercise #4

Exercise Name: Toe lift, standing

Reason for Exercise: Strengthening;Neuromuscular Training;Pain Control

Sets/Reps: 3 X 30 sec each

Resistance: Body Weight

Details: At home perform in the shower

Manual **Therapy** (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 40%)

Total Minutes (All Manual **Therapy**): 15

Assessment: Patient demonstrates reduced pain throughout her day and continues to roll feet on ice at night. Patient is compliant with HEP. Patient is improving, and will continue to stretch and strengthen for pain free status. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Total UNTIMED Code Treatment Minutes:
 Total TIMED Code Treatment Minutes: 30
 Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 9/25/2018 13:10

 Electronically signed by Abbott, Berniece, PTA at 09/25/2018 1:17 PM EDT

Progress Notes - Abbott, Berniece, PTA - 09/25/2018 11:59 PM EDT

The Guthrie Clinic
 Treatment Note
 Outpatient Physical **Therapy** Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL **THERAPY**
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

While doing my last note on 9/25/18, patient: Jennifer Lyn Brown, I noted I had made a mistake on the Time billed on the patient. The total time of this session should have been 34 minutes and not 64 minutes.

09/27/18
 Berniece Abbott, PTA
 16:04

Electronically signed by Abbott, Berniece, PTA at 09/27/2018 4:10 PM EDT

Addendum Note - Abbott, Berniece, PTA - 09/25/2018 11:59 PM EDT

Encounter addended by: Abbott, Berniece, PTA on: 9/27/2018 4:10 PM
 Actions taken: Sign clinical note

Electronically signed by Abbott, Berniece, PTA at 09/27/2018 4:10 PM EDT

Hospital Encounter

Robert Packer
Hospital
09/24/2018

09/24/2018	Office Visit	Auerbach, Brett, DO	Outpatient Impingement syndrome of left shoulder (Primary Dx); Bursitis of left shoulder; Arthritis of left acromioclavicular joint
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SAYRE
09/24/2018

Progress Notes - Auerbach, Brett, DO - 09/24/2018 1:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 9/24/2018

REFERRING PRACTITIONER: Self-Referred
 PRIMARY CARE PROVIDER: Gillan, Michael F

Patient presents with

- New Patient

Left Shoulder Pain, injured lifting a couch back in February 2018. Has had cortisone injections which give relief.

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female who presents for sports medicine referral for left shoulder pain. The patient sustained an injury to her left shoulder approximately 7 months ago in February 2018. She attempted to lift the couch when she noticed a sharp pain in her left shoulder. She continues to complain of pain on the anterior lateral aspect of the left shoulder which is worsened with overhead activity and lifting. She has occasional pain at night and difficulty sleeping as a **result** of this. She has treated this conservatively with therapeutic exercise, cortisone injections, activity modification, NSAIDs and icing. There is no cervical pain or upper extremity paresthesia present. She has had a recent **MRI** of the left shoulder performed which shows a type II acromion.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016

Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/2/2017

Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/11/2018

Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014

Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinha, Preetika, MD; Location: RPH MAIN OR
 • EGD N/A 6/24/2016
 Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
 • EGD N/A 6/2/2017
 Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
 • EGD N/A 6/11/2018
 Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
 • EGD (GUTHRIE / NON GUTHRIE)
 • LAPAROSCOPIC CHOLECYSTECTOMY 2013
 with liver **biopsy**
 • PR CLOSED RX TARSAL FX,EACH
 • PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
 for obesity - Dr. Alley - RPH
 • PR REMOVAL GALLBLADDER
 • TONSILLECTOMY 11/26/07

Family History
 Problem Relation Age of Onset
 • Diabetes Mother
 • Heart Mother
 • Hypertension Mother
 • Psychiatry Mother

Anxiety

• Arthritis Mother
 • Heart Disease Mother
 • Kidney Disease Mother
 • Diabetes Father
 • Hypertension Father
 • Genetic Father
 Marfan syndrome
 • Heart Father
 ?Marfan's Syndrome
 • Clotting Disorder Father
 • Heart Disease Father
 • Heart Paternal Uncle
 Aortic Dissection, Marfan's Syndrome
 • Heart Disease Paternal Uncle
 • Diabetes Maternal Grandfather
 • Thyroid Disease Maternal Grandfather
 • Macular Degeneration Paternal Grandmother
 • Psychiatry Maternal Aunt
 ADHD
 • Genetic Maternal Aunt
 Marfan syndrome
 • Psychiatry Other
 ADHD
 • **Cancer** Paternal Grandfather
 • Glaucoma No family history
 • Blindness No family history
 • Other Eye Problems No family history
 • Anesth Problems No family history

Current Outpatient Prescriptions

Medication Sig
 • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
 • calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
 • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
 • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
 • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
 • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting)
 • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
 • HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
 • levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LCF Document 18 Filed 08/27/23 Page 476 of 1112				
				EXHIBIT NO. B2F PAGE: 148 OF 309
				<ul style="list-style-type: none"> lisinopril (ZOSIN) 10 MG Oral Tab Take 1 Tab by mouth DAILY. loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY. Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS. ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY. predniSONE (DELTASONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS. venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-adminis tered medications for this visit.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Social History Main Topics

- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: negative for fevers, chills, weight loss and weight gain.
EYES: negative for visual disturbance and double vision.
EARS, NOSE, MOUTH, THROAT and FACE: negative for tinnitus, nasal congestion and sore throat.
RESPIRATORY: negative for cough, wheezing or short of breath.
CARDIOVASCULAR: negative for chest pain, palpitations, fatigue, tachypnea.
GASTROINTESTINAL : negative for dysphagia, nausea, diarrhea and constipation.
GENITOURINARY: negative for frequency, dysuria and urinary incontinence.
INTEGUMENT/BREAS T: negative for rash and skin lesion(s).
HEMATOLOGIC/LYMP HATIC: negative for easy bruising, bleeding, lymphadenopathy and history of blood clots.
NEUROLOGICAL: positive for headaches, dizziness, vertigo, seizures, paresthesia and tremor.
ENDOCRINE: negative for diabetic symptoms including polyuria and polydipsia.

PHYSICAL EXAMINATION:

General : Jennifer Lyn Brown is a well nourished, healthy appearing 41-y.o. female in no acute distress, conscious alert and oriented times three.
The patient standing within normal weightbearing line and ambulating with a normal **gait** pattern.
VITALS: BP 124/84 | Pulse 84 | Ht 5' 11" (1.803 m) | Wt 296 lb (134.3 kg) | BMI 41.28 kg/m² Body mass index is 41.28 kg/m².

PAIN SCORE: 2-6/10 with activity, 3/10 at rest.

Left shoulder:

Palpation

There is no erythema, warmth, or rubor.

No visible swelling. No acromioclavicular joint tenderness or SC joint tenderness
 positive - Biceps tenderness
 Crossed body adduction is negative without AC joint tenderness.

Motion
 ROM is 160 degrees of forward flexion. Abduction is 150 degrees.
 External rotation of the arm at the side is 45 degrees
 Internal rotation behind the back is now to S1.

Stability
 negative lift off test. negative belly press
 positive - Hawkins, positive - Neer
 positive - painful arc of abduction
 no instability. negative apprehension
 + 0 Load and shift exam

Muscle
 Strength of supraspinatus, infraspinatus, subscapularis 4/5.
 Muscle strength of his upper extremity reveal 5/5 strength triceps, hand intrinsics, wrist extensors, 5/5 biceps, wrist flexors.

Alignment
 No obvious deformity.
 Overall alignment is normal

Neurovascular
 Negative hoffmans sign, DTR's biceps 2/4, sensory and vascular exam of the upper extremity is normal.

Right shoulder:
 There is no erythema, ecchymosis or skin lesions present
 There is no warmth and no rubor.
 There no effusion.
 There is no crepitation.
 There is no tenderness to palpation.
 Alignment is normal.
 There is no shoulder girdle muscle atrophy
 There is full ROM.
 Strength is 5/5
 There is no weakness with rotator cuff testing
 Hawkins is negative.
 There is no gross instability.
 Sensation is intact and pulses are 2+.

DIAGNOSTIC STUDIES:

MRI left shoulder:
 1. Supraspinatus, infraspinatus, teres minor, and subscapularis tendons are intact.
 2. Mild lateral downsloping the acromion. Negative for proliferative changes at the AC joint or at the anterior inferior acromion. Negative for significant subacromial/subd eltoid bursal thickening or fluid accumulation.
 3. Glenoid labrum is intact.
 4. The biceps tendon is intact and normally located.
 5. Cartilage appears somewhat thin at the posterior glenoid.

IMPRESSION:
 ICD-9-CM ICD-10-CM
 1. Impingement syndrome of left shoulder 726.2 M75.42
 2. Bursitis of left shoulder 726.10 M75.52
 3. Arthritis of left acromioclavicular joint 716.91 M19.012

PLAN:
 41 year old female with continued left shoulder pain due to impingement syndrome, subacromial bursitis and acromioclavicular joint arthrosis having failed conservative treatment

- Discussed **imaging** studies and **diagnosis** in detail
- We discussed that she has failed conservative treatment
- Discussed continued conservative treatment versus left shoulder arthroscopic subacromial decompression/ac romioplasty, distal clavicle excision and possible biceps tenotomy.
- Discussed post-operative course and the need for physical **therapy**
- Surgical packet provided
- Follow up for pre-op visit will obtain scripts for PT and protocol. Pain medication will be provided on the day of surgery.

Risks including but not limited to pain, stiffness, blood clots, bleeding, infection, fractures, dislocations, implant failure, neurovascular injury, possible need for further surgery, adverse reactions to anesthesia, MI, TIA, CVA, death etc. were discussed. After discussing the **diagnosis** and **prognosis** we discussed the various treatment options available including surgical interventions. The relative potential risks, and benefits were discussed. The potential complications were discussed. The expected preoperative, intraoperative, and postoperative course was discussed in general terms. The importance of patient compliance in successful treatment was discussed. All questions were answered and the patient wishes to proceed with surgery. The patient will call if there are any changes in their health status or if there are any other questions we can answer. We will schedule the surgery at the patients convenience.

The risks and benefits of my recommendations, as well as other treatment options along with their benefits, risks, and failure rates were discussed with the patient today.
All questions were answered.

Author: Brett Auerbach, DO 9/24/2018 14:03

Electronically signed by Auerbach, Brett, DO at 09/25/2018 9:32 PM EDT

Nursing Note - Dolan, Megan H - 09/24/2018 1:00 PM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/24/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAS T: negative.
HEMATOLOGIC/LYMP HATIC: negative.
MUSCULOSKELETAL: negative. Except left shoulder pain.
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: negative.
ALLERGIC/IMMUNOL OGIC: negative.

AUTHOR: Megan H Dolan 9/24/2018 13:51

Electronically signed by Dolan, Megan H at 09/24/2018 1:52 PM EDT

09/20/2018	Hospital Encounter	Abbott, Berniece, PTA	Repeat Series
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Robert Packer Hospital
09/20/2018

Progress Notes - Abbott, Berniece, PTA - 09/20/2018 10:52 AM EDT

Formatting of this note might be different from the original.

Treatment Number: 2

Referring Physician: Michael Gorsline

Primary Diagnosis:

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1050

Time Out: 1120

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated her feet continue to be sore, let her know this condition took a long time to get and it will take a while to correct. She must do her stretches and exercises daily. Patient understood.

Interventions:

Therapeutic Exercises (97110)

Patient Education/Home Exercise Program: Educated pateint (Educated patient on OTC inserts to wear all the time.)

Number of Exercises?: 4

Total Minutes (all Therapeutic Exercise): 15

Exercise #1

Exercise Name: Plantarfascia stretch

Reason for Exercise: Flexibility;Func tional Mobility;Pain Control (Reduce stress on fascia)

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Func tional Mobility;Pain Control

Sets/Reps: 3 X 30 Sec. each

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking (Must move feet with circles, point toes,dorsiflex)

Reason for Exercise: Flexibility;Func tional Mobility;Muscle Performance;Pain Control

Location/Body Area: Bilateral;Foot;A nkle

Sets/Reps: 6 X

Resistance: None

Details: (Promotes blood flow, reduces tearing)

Exercise #4

Exercise Name: Toe lift, standing

Reason for Exercise: Strengthening;Ne uromuscular Training;Pain Control

Sets/Reps: 3 X 30 sec each

Resistance: Body Weight

Details: At home perform in the shower

Manual Therapy (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assis ted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 40%)

Assessment: Patient demonstrates understanding of the importance of stretching, OTC orthotics, Icing, movement before ambulating. Patient is motivated to work on this due to the pain that has been reduced since her SOC. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments.

Plan for Next Visit: Continue to reduce Soft tissue restriction in her calves and feet. Continue strengthening the plantar area of her feet.

Total UNTIMED Code Treatment Minutes:
 Total TIMED Code Treatment Minutes: 30
 Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 9/20/2018 11:33

Electronically signed by Abbott, Berniece, PTA at 09/20/2018 11:39 AM EDT

09/20/2018	Orders Only	Dolan, Megan H	
09/19/2018	Telephone	Shaw, Beth, RN	Medical Question

SAYRE

09/19/2018

Telephone Encounter - Shaw, Beth, RN - 09/19/2018 3:43 PM EDT

Patient needs refill of Vitamin D. Last Vitamin D level on 3/12/18 was 36.8. Patient questioning if Dr.Georgetson has any new recommendations prior to refill.

- How often should she have this checked?
- Does it need to be rechecked prior to refilling Vitamin D3 1000 units daily?

Please advise, thanks.
 Uses Clinic Pharmacy.

Electronically signed by Shaw, Beth, RN at 09/19/2018 4:03 PM EDT

Telephone Encounter - Georgetson, Michael J, MD FACG - 09/19/2018 4:57 PM EDT

OK to refill
 Would check again in Dec

Electronically signed by Georgetson, Michael J, MD FACG at 09/19/2018 4:57 PM EDT

Telephone Encounter - Shaw, Beth, RN - 09/20/2018 9:37 AM EDT

Patient informed of Dr.Georgetson's recommendations. Orders pended for Vitamin D prescription refill and for repeat lab in December. Please review and sign. Thanks.

Electronically signed by Shaw, Beth, RN at 09/20/2018 9:48 AM EDT

Lab

SAYRE

09/14/2018

Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC)
 Thumb pain, right (Primary Dx)

09/14/2018	Office Visit	Gorsline, Michael, PA-C
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SAYRE

09/14/2018

Progress Notes - Gorsline, Michael, PA-C - 09/14/2018 10:45 AM EDT

Formatting of this note might be different from the original.

Chief Complaint

Patient presents with

- Follow Up

Right thumb pain. Patient went to hand therapy, but they weren't sure what else to do, so they sent her back here. Pain radiates from her thumb up past her wrist, Pain right in the tip of the thumb, some days she has numbness

SUBJECTIVE:

Jennifer Lyn Brown is a 41-y.o. female who presents to the office today for evaluation of right thumb pain. She had been seen in the past for early trigger finger and was in occupational therapy. This has improved but she now goes onto complaint of pain over the tip of the thumb. No recent injury. Complains of occasional numbness/tingling. Uses a splint on occasion. Describes burning sensation at times and pressure pain at times. Also reports symptoms change and move. She is right handed. Currently on prednisone from Dr. Freeman.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016

Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/2/2017

Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/11/2018

Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 162 of 1112				EXHIBIT NO. B2F PAGE: 154 OF 309
	Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH MAIN OR			• EGD N/A 6/24/2016
	Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR			• EGD N/A 6/2/2017
	Procedure: ENDOSCOPY UPPER GI w/ BIOPSY ; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR			• EGD N/A 6/11/2018
	Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR			• EGD (GUTHRIE / NON GUTHRIE)
				• LAPAROSCOPIC CHOLECYSTECTOMY 2013
	with liver biopsy			
				• PR CLOSED RX TARSAL FX,EACH
				• PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
	for obesity - Dr. Alley - RPH			
				• PR REMOVAL GALLBLADDER
				• TONSILLECTOMY 11/26/07
	Family History			
	Problem Relation Age of Onset			
				• Diabetes Mother
				• Heart Mother
				• Hypertension Mother
				• Psychiatry Mother
	Anxiety			
				• Arthritis Mother
				• Heart Disease Mother
				• Kidney Disease Mother
				• Diabetes Father
				• Hypertension Father
				• Genetic Father
	Marfan syndrome			
				• Heart Father
	?Marfan's Syndrome			
				• Clotting Disorder Father
				• Heart Disease Father
				• Heart Paternal Uncle
	Aortic Dissection, Marfan's Syndrome			
				• Heart Disease Paternal Uncle
				• Diabetes Maternal Grandfather
				• Thyroid Disease Maternal Grandfather
				• Macular Degeneration Paternal Grandmother
				• Psychiatry Maternal Aunt
	ADHD			
				• Genetic Maternal Aunt
	Marfan syndrome			
				• Psychiatry Other
	ADHD			
				• Cancer Paternal Grandfather
				• Glaucoma No family history
				• Blindness No family history
				• Other Eye Problems No family history
				• Anesth Problems No family history
	Social History			
	Social History Main Topics			
				• Smoking status: Never Smoker
				• Smokeless tobacco: Never Used
				• Alcohol use No
				• Drug use: No
				• Sexual activity: Yes
	Partners: Male			
	Birth control/ protection: Pill, Condom			
	Comment: OCPs			
	Other Topics Concern			

Social History Narrative
August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- predniSONE (DELTASONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-administered medications for this visit.

Review of Systems:

Nursing Notes:

Cecce, Nicole, LPN 9/14/2018 10:35 AM Signed
NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/14/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAST: negative.
HEMATOLOGIC/LYMPHATIC: negative.
MUSCULOSKELETAL: negative except right thumb pain
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: negative.
ALLERGIC/IMMUNOLOGIC: Negative.

Body mass index is 41.28 kg/m². Patient aware

OBJECTIVE:

Physical Exam:
BP 130/72 Ht 5' 11" (1.803 m) Wt 296 lb (134.3 kg) BMI 41.28 kg/m2

Right thumb without swelling, eccymosis or gross deformity. Good alignment. No laxity at any level of the thumb or 1st metacarpal. Full motion at IP joint. Sore over the pulp of the finger. Good strength.

Diagnostic Data: X-rays of the right thumb reviewed and show no acute abnormality. Discussed in detail x-ray findings & implications with patient

ASSESSMENT:

ICD-9-CM ICD-10-CM
1. Thumb pain, right 729.5 M79.644

PLAN:

I cannot explain why she has thumb pain only over the pulp of the finger. She is on prednisone. She will get her esr and crp levels drawn today. May call Dr. Freeman for evaluation and second opinion.

Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated.

Author: Michael Gorsline, PA-C, ATC 9/14/2018 10:40

Electronically signed by Gorsline, Michael, PA-C at 09/14/2018 10:45 AM EDT

Nursing Note - Cecce, Nicole, LPN - 09/14/2018 10:45 AM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/14/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAS T: negative.
HEMATOLOGIC/LYMP HATIC: negative.
MUSCULOSKELETAL: negative except right thumb pain
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: negative.
ALLERGIC/IMMUNOL OGIC: Negative.

Body mass index is 41.28 kg/m². Patient aware

AUTHOR: Nicole Cecee, LPN 9/14/2018 10:35

Electronically signed by Cecce, Nicole, LPN at 09/14/2018 10:35 AM EDT
Wagner, James, OT

Trigger thumb of right hand
(Primary Dx)

SAYRE
09/12/2018

Progress Notes - Wagner, James, OT - 09/12/2018 1:00 PM EDT

Pt. Came in to therapy today with improvement in pain right thumb with use of orthotics however has a very specific c/o pain in the volar pulp of right thumb. There is no more intervention that I feel can be done at this time therapeutically. I cannot do with use of orthosis or a home program. I discussed case with referring provider and it was recommended she return for f/u visit. Pt. To Schedule visit with Michael Gorsline PA. D/C OT with HEP.

Robert Packer Hospital

09/12/2018

Progress Notes - Fritzen, Michael, PT - 09/12/2018 11:07 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Initial Evaluation
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-4801
570-888-6666

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 9/12/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Plantar fascial fibromatosis 728.71 M72.2

Time In: 1105
Time Out: 1140

Subjective: She is a 41-y.o.-year-old female who presents for outpatient physical **therapy** with a **chief complaint** of B/L foot pain.

Started wearing flip flops a lot 3 months ago L 1st then R, + 1st step pain L
L feet fx 4 yrs ago had cast NWB
Has had R Plantar fasciitis in past had PT and wore night splint 3 yrs ago.

No pain at rest, Walking R 2/10 , L 6/10
No end of day B/L 6/10

WORSE: Standing and walking
BETTER: rest and night splint

Still having shoulder problems getting cortisone shots

Prior Functional Status: walking a lot

Current Functional Status:
not walking dog

Abuse/Neglect Screening
Are you being threatened or hurt by anyone? : No

FOTO Data
Intake FS Score: 37
Predicted FS Score: 61

Objective:

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- **CT** 2005
- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
- Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2013
- with liver **biopsy**
- PR CLOSED RX TARSAL FX,EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
- for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
- TONSILLECTOMY 11/26/07

Date	Type	Specialty	Care Team	Description
Case: 6-21-cv-06189-LGF Document 18 Filed 08/27/23 Page 487 of 1112				
EXHIBIT NO. B2F PAGE: 159 OF 309				
Current Patient Prescriptions				
<ul style="list-style-type: none"> • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5 • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 30 Cap, Rfl: 5 • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses., Disp: 12 mL, Rfl: 0 • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0 • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3 • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0 • HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit, INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS, Disp: 4 Each, Rfl: 11 • levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 84 Tab, Rfl: 3 • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0 • Methotrexate 2.5 MG Oral Tab, Take 10 Tabs by mouth EVERY 7 DAYS., Disp: 120 Tab, Rfl: 4 • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1 • pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • predniSONE (DELTASONE) 10 MG Oral Tab, Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop, Disp: 30 Tab, Rfl: 0 • Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3 • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0 • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS., Disp: 90 Cap, Rfl: 0 • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 0 				

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

ANKLE L ROM R ROM L MMT R MMT

Dorsiflex gross 5 10 5 5

Plantarflex 50 50 5 5

Adduction

Abduction

Eversion 10 10

Inversion 30 30

1st toe ROM WNL

Inspection: no callous pattern

STN Dorsiflexion: L (0), R (-5)

STN HF: B/L 6 varus

FF: B/L Flexible Plantarflexed 1st ray

Tibial Varum 0

Stance: No excessive pronation

Gait: WNL

Plan of Care

Plan of Care Start Date: 09/12/18

Plan of Care Expiration Date: 12/12/18

Prior Function Comment: walking a lot

Current Function Comment: not walking dog

Rehabilitative **Prognosis:** Good

Planned Intervention(s): PT Eval Low Complexity (97161); **Gait** Training (97116); Therapeutic Exercise (Timed) (97110); Ultrasound (Timed) (97035); Manual **Therapy** (Timed) (97140); Orthotic Follow Up (97763) **483**

Frequency of Treatments: 2 times weekly

Duration of Treatments: 3 months

Assessment: Mrs. Brown was referred to PT 2nd B/L Plantar fasciitis pain L>R. She had fx L 5th Metatarsal 4 yrs ago. She has had past hx of Plantar fasciitis that resolved. It appears her pain started 2nd to wearing flip-flops. She gets + 1st step pain. Her symptoms are consistent clinically as Plantar fasciitis. She has excessive stiffness in L ankle Dorsiflexion and her L Plantar fascia has more tautness. I instructed no barefoot walking. We will educate on 1st step pain, and soft tissue mobilization Plantar fascia, calf stretches and Laser Plantar fascia. She might benefit from BFO offshelf orthotics we trial in future. She was thoroughly educated not to increase pain with prolonged walking. No red flag signs. Anticipated **prognosis** good if compliant (she never followed through with her shoulder PT).

Was Physical **Therapy** treatment performed at this visit?
Yes: Interventions:

FOTO Data
Intake FS Score: 37
Predicted FS Score: 61

Therapeutic Exercises (97110)
Number of Exercises?: 4
Total Minutes (all Therapeutic Exercise): 5

Exercise #1
Exercise Name: Plantar fascia stretch

Exercise #2
Exercise Name: Standing wall push calf stretch with inv

Exercise #3
Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual **Therapy** (97140)
Soft Tissue Mobilization Details: B/L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm² 2:30 and Graston #4 sweeps
Other Manual **Therapy** Treatment Performed: Laser infrared/red 6 J/cm² B/L plantar fascia with stretch
Total Minutes (All Manual **Therapy**): 15

Plan for Next Visit: Continue soft tissue and laser, review HEP, Review Education, Trial BFO's

Evaluation Complexity **Assessment:** History Components: Moderate (1-2 personal factors and/or comorbidities)
Examination of Body Systems/Components: Low (Addressing 1-2 elements)
Clinical Presentation: Evolving - changing/inconsistent clinical characteristics (Moderate)
Clinical Decision Making (complexity): Low

Treatment Number: 1
Total Time of Evaluation: 20
Total Number of Timed Code Treatment Minutes: 20

Author: Michael Fritzen, PT 9/12/2018 11:57

Electronically signed by Fritzen, Michael, PT at 09/12/2018 12:42 PM EDT

Therapy Plan of Care - Fritzen, Michael, PT - 09/12/2018 11:58 AM EDT

Formatting of this note might be different from the original.

RPH PHYSICIAN
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 9/12/2018

Referring Physician: Michael Gorsline

Plan of Care Start Date: 09/12/18

Plan of Care Expiration Date: 12/12/18

Primary **Diagnosis**:
 ICD-9-CM ICD-10-CM
 1. Plantar fascial fibromatosis 728.71 M72.2

Prior Functional Status: walking a lot

Current Functional Status:
 not walking dog

Rehabilitative **Prognosis**: Good

Short Goals: (2-4 wks)
 1) IND education
 2) IND 1st step pain control
 3) decrease pain 25% end of day

Long TErM Goals: (2-3 months)
 1) Decrease pain 50% end of day
 2) Intermittent pain walking
 3) increase functional status 24 points per FOTO survey
 4) resume walking dog pain limited

Planned Intervention(s): PT Eval Low Complexity (97161);**Gait** Training (97116);Therapeu tic Exercise (Timed) (97110);Ultrasou nd (Timed) (97035);Manual **Therapy** (Timed) (97140);Orthotic Follow Up (97763)
 The above planned interventions may be used in Physical **Therapy** treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: 2 times weekly

Duration of Treatment: 3 months

The Physical **Therapy** Plan of Care has been discussed with the patient . Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical **Therapy** treatment while under my care.

Gorsline, Michael, PA-C
 1 GUTHRIE SQUARE
 SAYRE, PA 18840 (To be Electronically signed)

Author: Michael Fritzen, PT 9/12/2018 11:58

Electronically signed by Gorsline, Michael, PA-C at 09/13/2018 8:34 AM EDT
 09/11/2018 Ocular Visit Galizia, Frank L, OD

Bilateral dry eyes (Pr 485 Dx)

Formatting of this note might be different from the original.

Patient Name: Jennifer Lyn Brown
MRN: 340616
Date of Birth: 10/26/1976

Assessment:

ICD-9-CM ICD-10-CM
1. Bilateral dry eyes 375.15 H04.123

Plan

Stressed daily tid use of Theratears, not once each day

Monitor in one year/PRN
Works in GI

Author: Frank L Galizia, OD

Electronically signed by Galizia, Frank L, OD at 09/11/2018 2:57 PM EDT
Refill Lantz, Tricia, LPN

GAD (generalized **anxiety** disorder)

SAYRE
09/10/2018

Telephone Encounter - Lantz, Tricia, LPN - 09/10/2018 3:18 PM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Pending Prescriptions Disp Refills
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR 90 Cap 1
Sig: Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR 90 Cap 3
Sig: Take 1 Cap by mouth DAILY.

Last seen: 7/6/18
last filled: 1/22/18

Electronically signed by Lantz, Tricia, LPN at 09/10/2018 3:19 PM EDT

Telephone Encounter - Gillan, Michael F, DO - 09/10/2018 3:35 PM EDT

Name: Jennifer Lyn Brown
DOB: 10/26/1976
MRN: 340616
Date of Service: 9/10/2018

Refilled after chart review.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 09/10/2018 3:36 PM EDT

SAYRE
09/05/2018

Telephone Encounter - Shaw, Beth, RN - 09/05/2018 2:42 PM EDT

Formatting of this note might be different from the original.

Message received from Luci Kabes,
Patient not feeling well. Placed on Prednisone for rheumatoid issues. After completing Prednisone course, now having diarrhea and feeling poorly.
predniSONE (DELTASONE) 10 MG Oral Tab 30 Tab 0/0 8/22/2018
Sig : Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop

Unable to reach patient at this time to obtain further assessment by phone. Will continue to attempt to reach out to patient. Currently takes Humira and Methotrexate for Crohn's. Please advise.

Electronically signed by Shaw, Beth, RN at 09/05/2018 2:51 PM EDT

Telephone Encounter - Shaw, Beth, RN - 09/05/2018 3:56 PM EDT

See previous message. Patient left another message stating she started having diarrhea over the weekend upon finishing Prednisone prescribed by Rheumatologist. Since then diarrhea has continued to increase each day. Patient questioning if Dr.Georgetson would advise she take additional course of Prednisone, previously prescribed by Dr.Georgetson. States she does have a refill left. Please advise on recommendations. Thanks.

Electronically signed by Shaw, Beth, RN at 09/05/2018 3:59 PM EDT

Telephone Encounter - Georgetson, Michael J, MD FACG - 09/05/2018 4:17 PM EDT

Yes that is reasonable given her hx

Electronically signed by Georgetson, Michael J, MD FACG at 09/05/2018 4:17 PM EDT

Telephone Encounter - Shaw, Beth, RN - 09/05/2018 4:21 PM EDT

Patient informed of Dr.Georgetson's recommendation and verbalized understanding/ag reement. Advised patient to give status report to either Dr.McDonald or Dr.Georgetson next week.

Electronically signed by Shaw, Beth, RN at 09/05/2018 4:23 PM EDT

08/29/2018	Office Visit	Wagner, James, OT	Trigger thumb of right hand (Primary Dx)
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SAYRE
08/29/2018

Progress Notes - Wagner, James, OT - 08/29/2018 11:00 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Occupational Therapy Services
SAYRE
SAYRE OCCUPATIONAL THERAPY
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976

Referring Physician: Michael Gorsline

Primary Diagnosis:

ICD-9-CM ICD-10-CM

1. Trigger thumb of right hand 727.03 M65.311

Subjective Comments: " Its about 50% better but its been bothering me mostly at the tip of my thumb."

Prior Functional Status:

Current Functional Status:

Comment: Pt. Reports reduction in thumb pain with use of orthosis. Pt.s primary c/o pain in at the thumb IP joint now at FPL insertion.

Systems Review/History of Current Problem: She is a 41-y.o.-year-old female.

Allergies, medications, and problem list were reviewed with the Patient.

Interventions:

Time In: 1105

Time Out: 1120

Visit Count: 2

Pain at the START of Treatment: 6/10

Pain at the END of Treatment: 6/10

New Orthosis

Type of Orthosis: (Thumb IP flexion block)

L-Code: L3933 - PR FO w/o Joints CF

Reason for Orthosis: Reduce Pain at the thumb IPJ level

Wearing Schedule: Other (see Comment) (In between use of other orthosis for pain control)

Total Minutes: 10

Intervention Comments: Alternate use of orthotics for pain control

Goals:

Short Term:

- 1) Decrease pain in right thumb with activity to 2/10 in 2-3 weeks.
- 2) Increase right thumb MCP flexion 15-20 degrees in 2-3 weeks.
- 3) Increase right grip strength 8-10 lbs in 2-3 weeks.

Long Term:

- 1) Jennifer will be able to carry a shopping bag without c/o pain by D/C.
- 2) Jennifer will be able to sleep with out c/o pain by D/C.

Plan: F/U in 2 weeks. If no decrease in pain initiate more formal hand on therapy interventions.

Total UNTIMED Code Minutes: 10

Total TIMED Code Minutes: 0

Total Treatment Minutes: 10

Author: James Wagner, OT 8/29/2018 11:22

Electronically signed by Wagner, James, OT at 08/29/2018 11:26 AM EDT

08/23/2018 Hospital Encounter

Robert Packer Hospital 08/23/2018	488
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Outpatient
Plantar fascial fibromatosis
(Primary Dx)

08/23/2018 Office Visit

Gorsline, Michael, PA-C

SAYRE**EXHIBIT NO. B2F
PAGE: 165 OF 309****08/23/2018****Progress Notes** - Gorsline, Michael, PA-C - 08/23/2018 11:30 AM EDT

Formatting of this note might be different from the original.

Name: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 8/23/2018

Chief Complaint

Patient presents with

- New Patient

left foot pain x 1 month worsening and middle of arch and right before heel pain

SUBJECTIVE:

Jennifer Lyn Brown is a 41-y.o. female who presents to the office today with a complaint of right foot pain. She has had symptoms for 3-4 weeks but reports it has gotten worse over the past 2 weeks. n injury. She locates pain over the heel of the foot into the arch. She thinks this is plantar fasciitis. She has had this in the past. She has tried home stretching without relief. Presents today for further evaluation and care.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013

• **Anxiety**

- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
 - **Depression** 1/20/2014
 - Endocrine problem
 - Epicondylitis elbow, medial 10/7/2008
 - Fatty liver
 - Fibromyalgia 8/20/2014
 - Fractures
 - Gastroparesis
 - irritable bowel syndrome
 - GERD (gastroesophagea l reflux disease) 10/7/2008
 - HTN (hypertension), benign 10/7/2008
 - Hypertension
 - Morbidly obese (HCC)
 - Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Past Surgical History:

Procedure Laterality Date

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 494 of 1112				EXHIBIT NO. B2F PAGE: 166 OF 309
				<ul style="list-style-type: none"> • COLONOSCOPY N/A 6/2/2017 Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR • COLONOSCOPY N/A 6/2/2017 Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR • COLONOSCOPY N/A 6/11/2018 Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR • COLONOSCOPY DIAGNOSTIC • EGD 2002 • EGD N/A 8/13/2014 Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A; • EGD N/A 6/24/2016 Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR • EGD N/A 6/2/2017 Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR • EGD N/A 6/11/2018 Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR • EGD (GUTHRIE / NON GUTHRIE) • LAPAROSCOPIC CHOLECYSTECTOMY 2013
				with liver biopsy <ul style="list-style-type: none"> • PR CLOSED RX TARSAL FX,EACH • PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
				for obesity - Dr. Alley - RPH
				<ul style="list-style-type: none"> • PR REMOVAL GALLBLADDER • TONSILLECTOMY 11/26/07
				Family History
				Problem Relation Age of Onset
				<ul style="list-style-type: none"> • Diabetes Mother • Heart Mother • Hypertension Mother • Psychiatry Mother
				Anxiety
				<ul style="list-style-type: none"> • Arthritis Mother • Heart Disease Mother • Kidney Disease Mother • Diabetes Father • Hypertension Father • Genetic Father
				Marfan syndrome
				• Heart Father
				?Marfan's Syndrome
				<ul style="list-style-type: none"> • Clotting Disorder Father • Heart Disease Father • Heart Paternal Uncle
				Aortic Dissection, Marfan's Syndrome
				<ul style="list-style-type: none"> • Heart Disease Paternal Uncle • Diabetes Maternal Grandfather • Thyroid Disease Maternal Grandfather • Macular Degeneration Paternal Grandmother • Psychiatry Maternal Aunt
				ADHD
				• Genetic Maternal Aunt
				Marfan syndrome
				• Psychiatry Other
				ADHD
				<ul style="list-style-type: none"> • Cancer Paternal Grandfather • Glaucoma No family history • Blindness No family history • Other Eye Problems No family history • Anesth Problems No family history

Social History

Social History Main Topics

- Smoking status: Never Smoker

- Smokeless tobacco: Never Used
- Alcohol use No
- Drug use: No
- Sexual activity: Yes

Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Allergies
Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Current Outpatient Prescriptions
Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- LEVONEST Oral Tab TAKE ONE TABLET BY MOUTH ONCE DAILY
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- predniSONE (DELTASONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-adminis tered medications for this visit.

Review of Systems:

Nursing Notes:
Swanson, Jodi, LPN 8/23/2018 12:05 PM Signed
8/23/2018.now
Jennifer Lyn Brown
10/26/1976
340616

CONSTITUTIONAL: negative
HEENT:negative
EYES:negative
RESPIRATORY:nega tive
CARDIOVASCULAR:n egative
GASTROINTESTINAL :negative
GENITOURINARY:ne gative
BREAST:negative

Body mass index is 40.45 kg/m². patient aware

Jodi Swanson, LPN

OBJECTIVE:

Physical Exam:

BP 124/82 Ht 5' 11" (1.803 m) Wt 290 lb (131.5 kg) BMI 40.45 kg/m2

Left foot without swelling, eccymosis or gross deformity. full range of motion of the ankle and foot and toes. Neurovascularly intact distally. Point tender over the heel of the foot extending into the mid-arch. Calf soft.

Diagnostic Data: X-rays show very small heal spur and healed 5th metatarsal base fracture. No acute **findings**.

ASSESSMENT:

ICD-9-CM ICD-10-CM

1. Plantar fascial fibromatosis 728.71 M72.2 DME OTHOPEDIC SUPPLIES (AMB)

REFER TO PHYSICAL **THERAPY** / REHAB

PLAN:

Recommended ice massage, non-steroidal anti-inflammatory medications, physical **therapy** for use of stretching and ultrasound along with night splints and shoe inserts. She will try all of these and follow-up as needed.

Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated.

Author: Michael Gorsline, PA-C, ATC 8/23/2018 12:31

Electronically signed by Gorsline, Michael, PA-C at 08/23/2018 12:31 PM EDT

Nursing Note - Swanson, Jodi, LPN - 08/23/2018 11:30 AM EDT

8/23/2018.now

Jennifer Lyn Brown

10/26/1976

340616

CONSTITUTIONAL: negative

HEENT:negative

EYES:negative

RESPIRATORY:negative

CARDIOVASCULAR:negative

GASTROINTESTINAL :negative

GENITOURINARY:negative

BREAST:negative

HEMATOLOGIC/LYMPHATIC:negative

NEUROLOGICAL:negative

BEHAVIORAL/PSYCH :negative

ENDOCRINE:negative

MUSCULOSKELETAL: positive left foot pain

Body mass index is 40.45 kg/m². patient aware

Jodi Swanson, LPN

Electronically signed by Swanson, Jodi, LPN at 08/23/2018 12:05 PM EDT

Office Visit

Freeman, James, MD

Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC) (Primary Dx), Enteropathic arthritis; Crohn's disease of small and large

SAYRE**08/22/2018****Progress Notes** - Rahman, Hammad, MD - 08/22/2018 1:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 8/22/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

flare

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female.

HPI

With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira later on humaira and methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Pt comes in for the one year follow up appointment. At this time, she was feeling fine until about 3 weeks ago when she started to notice some swelling of her both hands especially finger joints. Also complaining of some elbow stiffness. Her last arthritis flare was about 3 years ago and has been doing fairly well otherwise. She has been on the same dose of methotrexate and Humira for few years. Denies any fevers, chills, nodules, GI symptoms, back pain, toe swelling, knee pain, hip pain. Has been compliant with medications.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013

• **Anxiety**

- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity

- Persistent periauricular abscesses with conditions treated elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father

?Marfan's Syndrome

- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- LEVONEST Oral Tab TAKE ONE TABLET BY MOUTH ONCE DAILY
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.

Date	Type	Specialty	Care Team	Description
<p>Case 6:21-cv-06489-LGF Document 18 Filed 08/27/23 Page 499 of 1112</p> <p>EXHIBIT NO. B2F PAGE: 171 OF 309</p>				
				<ul style="list-style-type: none"> • pantoprazole (PRIL) 40 MG Oral Tab Take 1 tab by mouth DAILY • predniSONE (DELTASONE) 10 MG Oral Tab Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop • Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS. • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

No current facility-adminis tered medications for this visit.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Social History Main Topics

- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative for chills, diaphoresis, fever, malaise/fatigue and weight loss.

HENT: Negative for congestion, ear discharge, ear pain, hearing loss, nosebleeds and tinnitus.

Eyes: Negative for blurred vision, double vision, photophobia and pain.

Respiratory: Negative for cough, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal : Negative for abdominal pain, constipation, diarrhea, heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency, hematuria and urgency.

Musculoskeletal: Positive for joint pain (swelling and pain of interphalangeal joints, more on the left hand). Negative for back pain, falls, myalgias and neck pain.

Skin: Negative for rash.

Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, weakness and headaches.

Endo/Heme/Allerg ies: Does not bruise/bleed easily.

Psychiatric/Beha vioral: Negative for **depression** and memory loss.

Objective

PHYSICAL EXAM:

VITALS: BP 110/76 | Ht 5' 11" (1.803 m) | Wt 290 lb (131.5 kg) | BMI 40.45 kg/m² Body mass index is 40.45 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

Date	Type	Specialty	Care Team	Description
08/22/2018	06189-LGF	Document 18	Filed 08/27/23	Page 500 of 1112
				EXHIBIT NO. B2F PAGE: 172 OF 309
				<p>Eyes: Conjunctiva and sclera normal. Pupils equal, round and reactive to light.</p> <p>Neck: Normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.</p> <p>Cardiovascular: Normal rate, regular rhythm and intact distal pulses.</p> <p>No murmur heard.</p> <p>Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.</p> <p>Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.</p> <p>Musculoskeletal: She exhibits no edema or deformity.</p> <p>Right elbow: Normal. She exhibits normal range of motion.</p> <p>Left elbow: Normal. She exhibits normal range of motion.</p> <p>Right wrist: Normal.</p> <p>Left wrist: Normal.</p> <p>Right knee: Normal. She exhibits normal range of motion and no swelling.</p> <p>Left knee: Normal. She exhibits normal range of motion and no swelling.</p> <p>Right ankle: Normal. She exhibits no swelling.</p> <p>Left ankle: She exhibits normal range of motion and no swelling.</p> <p>Right hand: She exhibits tenderness and swelling. She exhibits normal range of motion and no bony tenderness.</p> <p>Left hand: She exhibits decreased range of motion, tenderness (3 lateral fingers of left hand), bony tenderness and swelling (3 lateral fingers of left hand). She exhibits no deformity and no laceration.</p> <p>Lymphadenopathy:</p> <p>She has no cervical adenopathy.</p> <p>Neurological: She is alert and oriented to person, place, and time. She has normal reflexes. No cranial nerve deficit. <u>Gait</u> normal. GCS score is 15.</p> <p>Skin: Skin is warm and dry. She is not diaphoretic.</p> <p>Psychiatric: Mood and affect normal.</p>

ASSESSMENT / IMPRESSION:

Plan

Rheumatoid arthritis/Entero pathic arthritis/Flare:

- Swelling of interphalangeal and metacarpo-phalan geal joint, more in left hand.
- CDAI score: 18.
- Will give patient prednisone 12 day course.
- Discussed with the patient option of switching oral methotrexate to injection as she has poor gut absorption. She call how she responds to prednisone.

Pt was seen and discussed with Dr. Freeman

Author: Hammad Rahman, MD 8/22/2018 20:15

Electronically signed by Rahman, Hammad, MD at 08/26/2018 8:56 AM EDT

Progress Notes - Freeman, James, MD - 08/22/2018 1:00 PM EDT

I saw and evaluated the patient. Discussed with resident and agree with the resident's **findings** and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 08/30/2018 9:10 AM EDT

08/22/2018	Orders Only	Desisti, Giuliana, ST	
08/20/2018	Telephone	Desisti, Deborah	Medication Question

SAYRE
08/20/2018

Telephone Encounter - Desisti, Deborah - 08/20/2018 1:08 PM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976

Pharmacy calls for B12 medicine they did receive the syringes but not the actual medication.thank-you

Author: Deborah Desisti 8/20/2018 13:08

Electronically signed by Desisti, Deborah at 08/20/2018 1:09 PM EDT

Telephone Encounter - Kremer, Anna, LPN - 08/20/2018 2:15 PM EDT

B12 ordered 8/17/18. Faxed order to pharmacy.
 Anna Kremer, LPN

Electronically signed by Kremer, Anna, LPN at 08/20/2018 2:16 PM EDT

08/17/2018	Orders Only	Georgetson, Michael J, MD FACG
08/17/2018	Telephone	Bissel, Kimberly L, FNP-C

Results

SAYRE

08/17/2018

Telephone Encounter - Bissel, Kimberly L, FNP-C - 08/17/2018 2:47 PM EDT

Left message to return call at 570-887-2530.

Pelvic ultrasound results.

See e-Guthrie message.

Electronically signed by Bissel, Kimberly L, FNP-C at 08/17/2018 2:49 PM EDT

Telephone Encounter - Burgess, Tonia, LPN - 08/20/2018 11:47 AM EDT

Tried to contact patient, phone was busy
 Tonia Burgess, LPN

Electronically signed by Burgess, Tonia, LPN at 08/20/2018 11:47 AM EDT

08/17/2018	Orders Only	Bissel, Kimberly L, FNP-C
08/15/2018	Telephone	Rollison, Michelle

SAYRE

08/15/2018

Telephone Encounter - Rollison, Michelle - 08/15/2018 8:17 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 8/15/2018

Pt calls to see if she can get her B12 shot today based on the labs she had done yesterday.
 Please advise the pt.
 Thank you

Author: Michelle Rollison 8/15/2018 08:17

Electronically signed by Rollison, Michelle at 08/15/2018 8:18 AM EDT

Telephone Encounter - Swain, Christina, LPN - 08/15/2018 8:24 AM EDT

Left message the levels were good and B12 not needed per conversation with Dr. Gillan last night

Electronically signed by Swain, Christina, LPN at 08/15/2018 8:24 AM EDT

Date	Type	Specialty	Care Team	Description
08/14/2018	Lab	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 503 of 1112		<div> <div>EXHIBIT NO. B2F</div> <div>08/14/2018</div> <div>PAGE 174 OF 309</div> </div>
08/13/2018	Hospital Encounter			<div> <div>Vitamin B 12 deficiency</div> <div>Robert Packer Hospital</div> <div>08/13/2018</div> </div>
08/08/2018	Office Visit		Wagner, James, OT	<div> <div>Outpatient</div> <div>Trigger thumb of right hand (Primary Dx)</div> </div>

SAYRE
08/08/2018

Progress Notes - Winsor, Shannon - 08/08/2018 10:30 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Evaluation
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 8/8/2018

Referring Physician: Michael Gorsline

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Trigger thumb of right hand 727.03 M65.311

Subjective Comments: "Last weekend I wanted to cut my thumb off it hurt so bad."

Prior Functional Status: Independent with no pain or functional limitation

Initial Inspection:
Date of Inital Evaluation: 08/08/18
Time In: 1030
Time Out: 1130
Pain at Rest: 2/10
Pain with Activity: 5/10
Pain at Best: 1/10
Pain at Worst: 8/10
Location of Pain: Most commonly at right thumb IP joint, but also at right thumb MCP
Exacerbating Factors: Lifting;Pushing; Pulling;Repetitive Grip
Relieving Factors: Ice;Medication

Systems Review/History of Current Problem: She is a 41-y.o.-year-old female. Pt. reports that her thumb has been swollen for about a week. It felt like a bee sting. She initially thought that it was due to her rheumatoid arthritis. She reports that she is experiencing a burning and itching in the IP joint of her right thumb.

Current Outpatient Prescriptions:

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-GF Document 18 Filed 02/27/23 Page 503 of 1112				
				EXHIBIT NO. B2F PAGE 175 OF 309
				<ul style="list-style-type: none"> • buPROPIONATE 10 MG Oral TAB, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5 • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 30 Cap, Rfl: 5 • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1,000 mcg within a muscle EVERY THIRTY DAYS., Disp: , Rfl: • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0 • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3 • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0 • HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit, INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS, Disp: 4 Each, Rfl: 11 • LEVONEST Oral Tab, TAKE ONE TABLET BY MOUTH ONCE DAILY, Disp: 84 Tab, Rfl: 0 • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0 • Methotrexate 2.5 MG Oral Tab, Take 10 Tabs by mouth EVERY 7 DAYS., Disp: 120 Tab, Rfl: 4 • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1 • pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 • Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3 • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS., Disp: 90 Cap, Rfl: 1 • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3 • Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap, Take 50,000 Units by mouth EVERY 7 DAYS., Disp: 12 Cap, Rfl: 1

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea l reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008

- Sees Dr. Freeman - 6/10/2013
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016

Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/2/2017

Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- COLONOSCOPY N/A 6/11/2018

Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- COLONOSCOPY DIAGNOSTIC

- EGD 2002

- EGD N/A 8/13/2014

Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;

- EGD N/A 6/24/2016

Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD N/A 6/2/2017

Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD N/A 6/11/2018

Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- EGD (GUTHRIE / NON GUTHRIE)

- LAPAROSCOPIC CHOLECYSTECTOMY 2013

with liver **biopsy**

- PR CLOSED RX TARSAL FX,EACH

- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014

for obesity - Dr. Alley - RPH

- PR REMOVAL GALLBLADDER

- TONSILLECTOMY 11/26/07

Measurement Data:

Edema: No edema noted at this time

Range of Motion:

Thumb ROM

R Thumb - MCP Joint: 30

R Thumb - IP Joint: 65

R Thumb - Palmar Abduction: 40

R Thumb - Opposition: Base of Small

L Thumb - MCP Joint: 60

L Thumb - IP Joint: 65

L Thumb - Palmar Abduction: 50

L Thumb - Opposition: Base of Small

PROM > AROM

No active triggering of thumb at this point, more boggy synovitis

Strength Testing:

1-3 Trial Testing

R - Grip #1: 39.6

R - Grip #2: 40.2

R - Grip #3: 39.7

R - Grip Average: 39.83

R - Lateral Pinch #1: 5.1

R - Lateral Pinch #2: 11.2

R - Lateral Pinch #3: 9.4

R - Lateral Pinch Average: 8.57

L - Grip #1: 57.4

L - Grip #2: 59.1

L - Grip #3: 46.6

L - Grip Average: 54.37

L - Lateral Pinch #1: 10.3

Sensation:

Semmes-Weinstein Monofilament Test

Right Thumb Tip: 2.83

Right Index Tip: 2.83

Right Middle Tip: 2.83

Right Ring Tip - Radial: 2.83

Right Ring Tip - Ulnar: 2.83

Right Small Tip: 2.83

Jennifer reports mild tingling sensation in her right thumb.

Quick Dash:

Quick Dash

Open a tight or new jar: Mild Difficulty

Do heavy Household chores (e.g. wash walls, floors): Moderate Difficulty

Carry a shopping bag or briefcase: Moderate Difficulty

Wash your back: Moderate Difficulty

Use a knife to cut food: Mild Difficulty

Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, hammering, tennis, etc.): Moderate Difficulty

During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups?: Quite a Bit

During the past week, were you limited in your work or other daily activities as a **result** of your arm, shoulder, or hand problem?: Slightly Limited

Rate the severity of the following symptoms in the last week: Arm, shoulder, or hand pain: Moderate

Rate the severity of the following symptoms in the last week: Tingling (pins and needles) in your arm, shoulder, or hand: Mild

During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?: Severe Difficulty

QuickDASH Score: 45.45

Impairment Observations: Jennifer is a 41 y/o female who presents with right thumb pain, decreased right thumb AROM, and decreased grip strength which affects her occupational performance.

Rehabilitation **Diagnosis**: Early flexor tenosynovitis of the FPL (trigger thumb)

Rehabilitative **Prognosis**: Good

Goals:

Short Term:

- 1) Decrease pain in right thumb with activity to 2/10 in 2-3 weeks.
- 2) Increase right thumb MCP flexion 15-20 degrees in 2-3 weeks.
- 3) Increase right grip strength 8-10 lbs in 2-3 weeks.

Long Term:

- 1) Jennifer will be able to carry a shopping bag without c/o pain by D/C.
- 2) Jennifer will be able to sleep with out c/o pain by D/C.

Interventions/Plan:

Intervention Comments: The following interventions may be used in OT for treatment of patient's condition: Therapeutic Activity 97530; Infrared 97026; Self Care 97535; Paraffin 97018; Manual **Therapy** 97140; OT R-Evaluation; Neuromuscular Re-Education 97112; Ultrasound 97035; Fluido **Therapy** 97022; Therapeutic Exercise 97110; E-Stim 97032; Vasopneumatic Device 97016; and any orthotic devices as indicated.

Was Occupational **Therapy** treatment performed at this visit? Yes

New Orthosis

Type of Orthosis: (P) Hand based thumb spica

L-Code: (P) L3913 - PR HFO w/o Joints CF

Reason for Orthosis: (P) Reduce Pain

Wearing Schedule: (P) At night;During activity;Other (see Comment) (As needed for pain relief)

Total Minutes: (P) 15

Duration of Treatment: 3 months

Patient concurs with established treatment and goals.

Total Timed Code Minutes: 45
Total Treatment Minutes: 60

Author: Shannon Winsor 8/8/2018 11:42

Electronically signed by Wagner, James, OT at 08/08/2018 12:01 PM EDT

Therapy Plan of Care - Winsor, Shannon - 08/08/2018 10:30 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Plan of Care
Outpatient Occupational **Therapy** Services
SAYRE
SAYRE OCCUPATIONAL **THERAPY**
1 Guthrie Square
Sayre PA 18840-1625
570-887-2201
570-888-5858

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 8/8/2018

Referring Physician: Michael Gorsline

Plan of Care Start Date: 08/08/18

Primary **Diagnosis**:
ICD-9-CM ICD-10-CM
1. Trigger thumb of right hand 727.03 M65.311

Subjective Comments: "Last weekend I wanted to cut my thumb off it hurt so bad."

Prior Functional Status: Independent with no pain or functional limitation

Rehabilitative **Prognosis**: Good

Systems Review/History of Current Problem: She is a 41-y.o.-year-old female. History of Current Problem: Pt. reports that her thumb has been swollen for about a week. It felt like a bee sting. She initially thought that it was due to her rheumatoid arthritis. She reports that she is experiencing a burning and itching in the IP joint of her right thumb.

Impairment Observations: See evaluation

Interventions/PI an: See evaluation

Intervention Comments: Intervention Comments: The following interventions may be used in OT for treatment of patient's condition: Therapeutic Activity 97530; Infrared 97026; Self Care 97535; Paraffin 97018; Manual **Therapy** 97140; OT R-Evaluation; Neuromuscular Re-Education 97112; Ultrasound 97035; Fluido **Therapy** 97022; Therapeutic Exercise 97110; E-Stim 97032; Vasopneumatic Device 97016; and any orthotic devices as indicated.

Frequency of Treatment: 1-2 times a week

Duration of Treatment: 3 months

I certify the need for these services furnished under this plan Occupational **Therapy** treatment while under my care. PAGE: 179 OF 180

Gorsline, Michael, PA-C
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: Shannon Winsor 8/8/2018 11:48

Electronically signed by Gorsline, Michael, PA-C at 08/08/2018 12:17 PM EDT
Hospital Encounter

**Robert Packer
Hospital
08/08/2018**

Outpatient
Trigger thumb of right hand
(Primary Dx)

SAYRE
08/08/2018

Progress Notes - Gorsline, Michael, PA-C - 08/08/2018 9:45 AM EDT

Formatting of this note might be different from the original.

Name: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 8/8/2018

Chief Complaint

Patient presents with

- New Patient

Patient reports right thumb pain for about a week. No known injury

- Thumb Pain

SUBJECTIVE:

Jennifer Lyn Brown is a 41-y.o. female who presents to the office today with a complaint of right thumb pain. She reports some mild swelling over the IP joint of the thumb. No injury. She is right handed. She reports a history of rheumatoid arthritis. She has had pain in the thumb for about 1 week. No treatment thus far. Presents today for further evaluation and care.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013

- **Anxiety**

- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
 - **Depression** 1/20/2014
 - Endocrine problem
 - Epicondylitis elbow, medial 10/7/2008
 - Fatty liver
 - Fibromyalgia 8/20/2014
 - Fractures
 - Gastroparesis
- irritable bowel syndrome

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 508 of 1112				
				EXHIBIT NO. B2F PAGE: 180 OF 309
				<ul style="list-style-type: none"> • GERD (Gastroesophageal Reflux Disease) 10/7/2008 • HTN (hypertension), benign 10/7/2008 • Hypertension • Morbidly obese (HCC) • Multinodular goiter • Nontoxic multinodular goiter 1/18/2011 • Obesity • Persistent mental disorders due to conditions classified elsewhere • Physiological ovarian cysts 10/7/2008 • PLANTAR FIBROMATOSIS 9/9/2004 • Premenopausal patient • Rheumatoid arthritis(714.0) 12/12/2008 <p>Sees Dr. Freeman in Elmira.</p> <ul style="list-style-type: none"> • Severe obstructive sleep apnea 6/10/2013 • Sleep apnea • Thyroid nodule 6/3/2010 • Wrist fracture <p>Past Surgical History:</p> <p>Procedure Laterality Date</p> <ul style="list-style-type: none"> • COLONOSCOPY N/A 6/24/2016 <p>Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</p> <ul style="list-style-type: none"> • COLONOSCOPY N/A 6/2/2017 <p>Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</p> <ul style="list-style-type: none"> • COLONOSCOPY N/A 6/11/2018 <p>Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</p> <ul style="list-style-type: none"> • COLONOSCOPY DIAGNOSTIC • EGD 2002 • EGD N/A 8/13/2014 <p>Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;</p> <ul style="list-style-type: none"> • EGD N/A 6/24/2016 <p>Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</p> <ul style="list-style-type: none"> • EGD N/A 6/2/2017 <p>Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</p> <ul style="list-style-type: none"> • EGD N/A 6/11/2018 <p>Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</p> <ul style="list-style-type: none"> • EGD (GUTHRIE / NON GUTHRIE) • LAPAROSCOPIC CHOLECYSTECTOMY 2013 <p>with liver biopsy</p> <ul style="list-style-type: none"> • PR CLOSED RX TARSAL FX,EACH • PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014 <p>for obesity - Dr. Alley - RPH</p> <ul style="list-style-type: none"> • PR REMOVAL GALLBLADDER • TONSILLECTOMY 11/26/07 <p>Family History</p> <p>Problem Relation Age of Onset</p> <ul style="list-style-type: none"> • Diabetes Mother • Heart Mother • Hypertension Mother • Psychiatry Mother <p>Anxiety</p> <ul style="list-style-type: none"> • Arthritis Mother • Heart Disease Mother • Kidney Disease Mother • Diabetes Father • Hypertension Father • Genetic Father <p>Marfan syndrome</p> <ul style="list-style-type: none"> • Heart Father <p>?Marfan's Syndrome</p> <ul style="list-style-type: none"> • Clotting Disorder Father • Heart Disease Father • Heart Paternal Uncle <p>Aortic Dissection, Marfan's Syndrome</p>

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt
- ADHD
- Genetic Maternal Aunt
- Marfan syndrome
- Psychiatry Other
- ADHD
- Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Social History

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No
- Drug use: No
- Sexual activity: Yes

Partners: Male

Birth control/ protection: Pill, Condom

Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1,000 mcg within a muscle EVERY THIRTY DAYS.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- LEVONEST Oral Tab TAKE ONE TABLET BY MOUTH ONCE DAILY
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAUVER T) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap Take 50,000 Units by mouth EVERY 7

No current facility-adminis tered medications for this visit.

Review of Systems:

Nursing Notes:
Firestine, Brandy, LPN 8/8/2018 10:11 AM Signed
NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 8/8/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAS T: negative.
HEMATOLOGIC/LYMP HATIC: negative.
MUSCULOSKELETAL: Positive right thumb pain
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: Negative.
ALLERGIC/IMMUNOL OGIC: Negative.

Body mass index is 41.28 kg/m². Patient aware

AUTHOR: Brandy Firestine, LPN 8/8/2018 10:10

OBJECTIVE:

Physical Exam:
BP 128/60 Ht 5' 11" (1.803 m) Wt 296 lb (134.3 kg) BMI 41.28 kg/m2

Right thumb with minimal swelling over the IP joint. full range of motion of the IP joint without pain to direct palpation. Metacarpal phalangeal joint is non-tender to palpation and CMC joint non-tender to palpation. - grind test. No laxity. Good alignment. Increased pain over A1 pulley of right thumb. Decreased grip strength when compared bilaterally.

Diagnostic Data: X-rays show no acute bony abnormality. Discussed in detail **x-ray findings** & implications with patient

ASSESSMENT:

ICD-9-CM ICD-10-CM
1. Trigger thumb of right hand 727.03 M65.311 REFER TO OCCUPATIONAL **THERAPY** / REHAB

PLAN:
She examines as though the A1 pulley is inflamed. Treatment discussed to include rest, ice, non-steroidal anti-inflammator y medications, cortisone or occupational **therapy**. We cannot use non-steroidal anti-inflammator y medications due to her Crohn's disease. She will use ice and she'd like to do occupational **therapy** as she has done this in the past with success.

Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated.

Author: Michael Gorsline, PA-C, ATC 8/8/2018 10:34

Electronically signed by Gorsline, Michael, PA-C at 08/08/2018 10:35 AM EDT

Nursing Note - Firestine, Brandy, LPN - 08/08/2018 9:45 AM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 8/8/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.

GENITOURINARY: negative.
INTEGUMENT/BREAST: negative.
HEMATOLOGIC/LYMPHATIC: negative.
MUSCULOSKELETAL: Positive right thumb pain
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: Negative.
ALLERGIC/IMMUNOLOGIC: Negative.

Body mass index is 41.28 kg/m². Patient aware

AUTHOR: Brandy Firestine, LPN 8/8/2018 10:10

Electronically signed by Firestine, Brandy, LPN at 08/08/2018 10:11 AM EDT

08/06/2018	Orders Only	Westbrook, Heather, LPN
07/31/2018	Office Visit	Green, Jonathan, PA

Impingement syndrome of left shoulder (Primary Dx);
Chronic left shoulder pain

SAYRE
07/31/2018

Progress Notes - Green, Jonathan, PA - 07/31/2018 3:15 PM EDT

Formatting of this note might be different from the original.

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 7/31/2018

Chief Complaint

Patient presents with
• Follow-up
Follow up with left shoulder pain.

HPI: Jennifer Lyn Brown is a 41-y.o. female for recurrence of pain in her left shoulder secondary to impingement syndrome. About 3 months ago she received posterior subacromial injection with very relief until a few weeks ago. No known injury. She complains of pain about the lateral aspect of the shoulder worse with any attempted range of motion above shoulder level or behind her back. Other treatments have included over-the-counter and prescription strength anti-inflammatories without relief. She denies any neck pain, back pain or numbness or tingling about the left upper extremity. She denies weakness to left upper extremity. Previous x-rays of the left shoulder demonstrate no acute chronic bony normality. Subacromial spaces appear to be adequate. Before meals joint is unremarkable. Glenohumeral joint appears be unremarkable. Recent **MRI** demonstrates laterally downsloping acromion but otherwise appears unremarkable.

PAST MEDICAL HISTORY: has a past medical history of Anal fissure (1/2013); **Anxiety**; Attention deficit; Back ache (3/18/2014); Calcaneal spur (6/30/2008); Cherry angioma (8/9/2016); Cholecystitis; CHRONIC SINUSITIS NOS (5/23/2005); Crohn disease (HCC); **Depression** (1/20/2014); Endocrine problem; Epicondylitis elbow, medial (10/7/2008); Fatty liver; Fibromyalgia (8/20/2014); Fractures; Gastroparesis; GERD (gastroesophageal reflux disease) (10/7/2008); HTN (hypertension), benign (10/7/2008); Hypertension; Morbidly obese (HCC); Multinodular goiter; Nontoxic multinodular goiter (1/18/2011); Obesity; Persistent mental disorders due to conditions classified elsewhere; Physiological ovarian cysts (10/7/2008); PLANTAR FIBROMATOSIS (9/9/2004); Premenopausal patient; Rheumatoid arthritis(714.0) (12/12/2008); Severe obstructive sleep apnea (6/10/2013); Sleep apnea; Thyroid nodule (6/3/2010); and Wrist fracture.

PAST SURGICAL HISTORY: has a past surgical history that includes tonsillectomy (11/26/07); egd (2002); egd (guthrie / non guthrie); laparoscopic cholecystectomy (2013); egd (N/A, 8/13/2014); pr lap, gast restrict proc, longitudinal gastrectomy (12/10/2014); pr removal gallbladder; pr closed rx tarsal fx,each; colonoscopy (N/A, 6/24/2016); egd (N/A, 6/24/2016); colonoscopy diagnostic; colonoscopy (N/A, 6/2/2017); egd (N/A, 6/2/2017); colonoscopy (N/A, 6/11/2018); and egd (N/A, 6/11/2018).

MEDICATIONS:
Current Outpatient Prescriptions:
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfi: 3

Date	Type	Specialty	Care Team	Description
<div>Case 6:21-cv-06189-LOF Document 18 Filed 08/27/21 Page 512 of 1402</div> <div>EXHIBIT NO. B2F</div> <div>PAGE 184 OF 309</div>				
				<ul style="list-style-type: none"> calcium carbonate (CAL-VA) 1000 MCG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 5 Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 30 Cap, Rfl: 5 cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1,000 mcg within a muscle EVERY THIRTY DAYS., Disp: , Rfl: cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0 EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3 fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0 HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit, INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS, Disp: 4 Each, Rfl: 11 LEVONEST Oral Tab, TAKE ONE TABLET BY MOUTH ONCE DAILY, Disp: 84 Tab, Rfl: 0 lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0 Methotrexate 2.5 MG Oral Tab, Take 10 Tabs by mouth EVERY 7 DAYS., Disp: 120 Tab, Rfl: 4 ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1 pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3 Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3 venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS., Disp: 90 Cap, Rfl: 1 venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3 Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap, Take 50,000 Units by mouth EVERY 7 DAYS., Disp: 12 Cap, Rfl: 1

ALLERGIES: She is allergic to bee stings [bee sting]; remicade [infliximab]; and tape: silk or adhesive.

SOCIAL HISTORY: She reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

FAMILY HISTORY: She family history includes Arthritis in her mother; **Cancer** in her paternal grandfather; Clotting Disorder in her father; Diabetes in her father, maternal grandfather, and mother; Genetic in her father and maternal aunt; Heart in her father, mother, and paternal uncle; Heart Disease in her father, mother, and paternal uncle; Hypertension in her father and mother; Kidney Disease in her mother; Macular Degeneration in her paternal grandmother; Psychiatry in her maternal aunt, mother, and other; Thyroid Disease in her maternal grandfather.

ROS: See HPI otherwise all other ROS are negative at this time

Exam:

General appearance: alert, well appearing, and in no distress, oriented to person, place, and time and overweight.

Vitals: Blood pressure 132/88, height 5' 11" (1.803 m), weight 286 lb (129.7 kg), not currently breastfeeding. Body mass index is 39.89 kg/m².

Neck: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. No bony or soft tissue tenderness. Unrestricted range of motion without pain or reproduction of pain.

Upper back: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. No pain to any bony or soft tissue aspect of the upper back:

Left Shoulder: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. There is no clinical deformity of the right shoulder. She has tenderness about the subacromial space. There is no chronic clavicular joint tenderness. There is no sternoclavicular joint tenderness. There is no scapular tenderness. There is no paraspinal muscular tenderness. There are no trigger points. There is no other bony or soft tissue tenderness about the shoulder. Her active range of motion is limited to approximately 90° of forward flexion, 90° of abduction, internal rotation to the left sacroiliac joint area, external rotation to the top of her head. Active range of motion is limited by pain. Passive range of motion is increased by about 10° in all directions but limited by pain. She demonstrated a positive hawkins test with motion limited to 30 degrees, external rotation in abduction about 60 degrees. She demonstrates a positive Neer sign with forward flexion and internal rotation with range of motion limited to about 45 degrees. She demonstrated negative RC testing with a negative drop arm sign, negative empty can sign negative for lower test, negative push off and lift off test, negative hornblower test. There is mild reproduction of pain with rotator cuff testing but good strength. Muscular strength appeared to be equal to the opposite side with good strength with resisted

ASSESSMENT:

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42
2. Chronic left shoulder pain 719.41 M25.512 INJECTION, JOINT SHOUDLER HIP KNEE OR BURSA 338.29 G89.29 methylPREDNISolone acetate (DEPO-MEDROL) injection 80 MG/ML

PLAN:

Treatment options for the above was discussed in detail. All of her questions and concerns were addressed her satisfaction. At this time she will like to have a cortisone injection fpr her left shoulder and start outpatient physical therapy.

Using usual sterile technique she was administered a posterior subacromial cortisone injection to the left shoulder with 80 mg DepoMedrol and 8 cc 1% plain lidocaine. She tolerated the procedure well without complications. She was re-evaluated about 5 minutes after the injection and was found to have improved range of motion and resolved pain. She was instructed to use ice and tylenol for any post injection discomfort

She will follow up if needed.

Author: Jonathan Green, PA 7/31/2018 16:23

Electronically signed by Green, Jonathan, PA at 07/31/2018 4:23 PM EDT

Nursing Note - Meyn, William, RN - 07/31/2018 3:15 PM EDT

NAME: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 7/31/2018

CONSTITUTIONAL: negative.
HEENT: negative.
EYES: negative.
RESPIRATORY: negative.
CARDIOVASCULAR: negative.
GASTROINTESTINAL : negative.
GENITOURINARY: negative.
INTEGUMENT/BREAS T: negative.
HEMATOLOGIC/LYMP HATIC: negative.
MUSCULOSKELETAL: Negative except Left Shoulder Pain.
NEUROLOGICAL: negative.
BEHAVIORAL/PSYCH : negative.
ENDOCRINE: negative.
ALLERGIC/IMMUNOL OGIC: negative.

AUTHOR: William Meyn, RN 7/31/2018 15:33

Electronically signed by Meyn, William, RN at 07/31/2018 4:23 PM EDT

07/18/2018 Telephone Barattucci, Tammy Other (Can)

SAYRE

07/18/2018

Telephone Encounter - Barattucci, Tammy - 07/18/2018 1:37 PM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 7/18/2018

Patient has called and cancelled appointment scheduled on 7/18/18 with Dr.Galizia, she rescheduled to 9/11/18

Author: Tammy Barattucci 7/18/2018 13:37

Electronically signed by Barattucci, Tammy at 07/18/2018 1:38 PM EDT

EXHIBIT NO. B2F

PAGE 184 OF 309
Robert Packer
Hospital
07/06/2018

07/06/2018 Hospital Encounter

07/06/2018 Office Visit Harbison, Alicia, DO Outpatient
Knee swelling (Primary Dx)

SAYRE
07/06/2018

Progress Notes - Harbison, Alicia, DO - 07/06/2018 9:20 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 7/6/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Knee Pain

Right knee pain. Fell about 2 months ago at home. Landed on right knee.

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female.

HPI

Patient is here to discuss right knee pain. She fell about 2 months ago, climbed over the baby gate, and landed on her right knee. It bruised significantly. Anytime she kneels, bumps into things, it hurts really badly. No injuries to the past. No swelling. No signs of locking, clicking, or feel like her knees going to give out. Patient hasn't taken medication. Uses flexeril occasionally (prescribed for back), cannot really use NSAIDs due to Crohns. Burning sensation. Hurts on the superior portion of the patella. It is exacerbated by motion, kneeling, hitting it. It improves with sleep. The pain is a 3/10.

PMHx: Crohn's disease and RA on Humira.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophagea I reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)

- Multinodular goiter
 - Nontoxic multinodular goiter 1/18/2011
 - Obesity
 - Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

- Family History
- Problem Relation Age of Onset
- Diabetes Mother
 - Heart Mother
 - Hypertension Mother
 - Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
 - Heart Disease Father
 - Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1,000 mcg within a muscle EVERY THIRTY DAYS.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- LEVONEST Oral Tab TAKE ONE TABLET BY MOUTH ONCE DAILY
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.

Date	Type	Specialty	Care Team	Description
Case 6:21-cv-06189-LGS Document 18 Filed 02/27/23 Page 516 of 516	ondansetron (ZEMET) 8 MG Oral Capsule SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS AS NEEDED for nausea.			EXHIBIT NO. B2F PAGE: 188 OF 309
	pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.			
	Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn			
	venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.			
	venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.			
	Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap Take 50,000 Units by mouth EVERY 7 DAYS.			

Current Facility-Administered Medications

Medication

- lidocaine (XYLOCAINE) injection 1 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Social History Main Topics

- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Genitourinary: Negative for dysuria and frequency.

Musculoskeletal: Positive for falls and joint pain.

Neurological: Negative for dizziness and tingling.

Endo/Heme/Allerg ies:

Did bruise.

Objective

PHYSICAL EXAM:

VITALS: BP 122/86 (BP Location: Right arm, Patient Position: Sitting) | Pulse 76 | Temp 97.6 °F (36.4 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 285 lb 4.8 oz (129.4 kg) | SpO2 98% | BMI 39.79 kg/m² Body mass index is 39.79 kg/m².

Physical Exam

Constitutional: She is well-developed, well-nourished, and in no distress. No distress.

HENT:

Head: Normocephalic and atraumatic.

Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.

Eyes: EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple. No tracheal deviation present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no friction rub. No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. She has no wheezes.

Musculoskeletal: Normal range of motion. She exhibits edema.

Right knee: She exhibits swelling and effusion. She exhibits no ecchymosis. Tenderness found. Medial joint line and lateral joint line tenderness noted. No patellar tendon tenderness noted.

Legs:

Lymphadenopathy:

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Knee swelling 719.06 M25.469 ANAEROBIC CULTURE (C&S)

GRAM STAIN

lidocaine (XYLOCAINE) injection 1 %

FINE NEEDLE ASPIRATION W/O **IMAGING**

JOINT ASPIRATION/INJECTION

ANAEROBIC CULTURE (C&S)

GRAM STAIN

Plan

Knee swelling:

-knee looks like it has significant effusion. Aspirated and removed 0.5cc.

-will not treat with steroid injection at this time until no signs of infection

Patient seen and discussed with Dr. Garcia-Ryan who agrees with the above **assessment** and plan.

Author: Alicia Harbison, DO 7/6/2018 11:14

Electronically signed by Harbison, Alicia, DO at 07/06/2018 11:17 AM EDT

Progress Notes - Garcia-Ryan, Gabriel, DO - 07/06/2018 9:20 AM EDT

Guthrie Clinic/RPH Supervising DO Documentation

Date of Service: 7/6/2018 B#: 340616

I saw and evaluated the patient. I discussed the patient with the resident. I agree with the **assessment**, diagnostic and treatment plan as documented in the resident's note.

Additional comments as indicated:

· Clinically looked like an effusion of knee, minimal aspiration. Straw colored about 1 cc fluid. Tolerated well.

· Get **x-ray**, send fluid for analysis (if possible), plan for steroid injection later next week (wanted to rule out septic arthritis given immunosuppressed status).

Gabriel Garcia-Ryan, DO

Supervising Physician

Department of Family Medicine

Electronically signed by Garcia-Ryan, Gabriel, DO at 07/06/2018 11:17 AM EDT

Procedures - Harbison, Alicia, DO - 07/06/2018 9:20 AM EDT

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 7/6/2018

Joint Aspiration/Injection

Date/Time: 7/6/2018 10:46 AM

Performed by: HARBISON, ALICIA

Authorized by: HARBISON, ALICIA

Indications: pain

Body area: knee

Joint: right knee

Local anesthesia used: yes

Anesthesia:

Local anesthesia used: yes

Local Anesthetic: lidocaine 1% without epinephrine

Sedation:
 Patient sedated: no
 Needle size: 22 G
 Ultrasound guidance: no
 Fluoroscopy guidance: no
 Approach: lateral
 Aspirate: clear
 Aspirate amount: 0.5 mL
 Patient tolerance: Patient tolerated the procedure well with no immediate complications
 Comments: Dr. Garcia-Ryan was present for the entire procedure.

Author: Alicia Harbison, DO 7/6/2018 10:46

 Electronically signed by Harbison, Alicia, DO at 07/06/2018 10:47 AM EDT

 Nursing Note - Lantz, Tricia, LPN - 07/06/2018 9:20 AM EDT

Formatting of this note might be different from the original.

 PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/6/2018

Chief Complaint
 Patient presents with
 • Knee Pain
 Right knee pain. Fell about 2 months ago at home. Landed on right knee.

Author: Tricia Lantz, LPN 7/6/2018 09:26

 Electronically signed by Lantz, Tricia, LPN at 07/06/2018 9:33 AM EDT
 07/06/2018 Telephone Sinsabaugh, Suzanne Other

SAYRE 07/06/2018

Telephone Encounter - Sinsabaugh, Suzanne - 07/06/2018 10:24 AM EDT

 PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/6/2018

 Patient was just seen and told to go get xray of knee, and make follow up for injection in 3 days.
 Xray has not been ordered, please order
 No one has availability in 3 days and who would precept the injection. Not everyone does those.

 Author: Suzanne Sinsabaugh 7/6/2018 10:24

 Electronically signed by Sinsabaugh, Suzanne at 07/06/2018 10:26 AM EDT

 Telephone Encounter - Sinsabaugh, Suzanne - 07/06/2018 11:08 AM EDT

 PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/6/2018

 Patient aware of xray order but I still need to know who is going to do injection and precept it.

 Author: Suzanne Sinsabaugh 7/6/2018 11:08

 Electronically signed by Sinsabaugh, Suzanne at 07/06/2018 11:08 AM EDT

Telephone Encounter - Harbison, Alicia, DO 07/06/2018 15:25 EDT
 PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/6/2018

Please have patient be seen by me at my next available appointment.
 Thank you!

Author: Alicia Harbison, DO 7/6/2018 15:25
 Electronically signed by Harbison, Alicia, DO at 07/06/2018 3:26 PM EDT
 Telephone Encounter - Sinsabaugh, Suzanne - 07/09/2018 8:07 AM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/9/2018

Left message to call me back
 Author: Suzanne Sinsabaugh 7/9/2018 08:07
 Electronically signed by Sinsabaugh, Suzanne at 07/09/2018 8:07 AM EDT
 Telephone Encounter - Sinsabaugh, Suzanne - 07/09/2018 2:11 PM EDT

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 7/9/2018

Appointment scheduled for 8/3/18
 Author: Suzanne Sinsabaugh 7/9/2018 14:11
 Electronically signed by Sinsabaugh, Suzanne at 07/09/2018 2:11 PM EDT

06/25/2018
 Hospital Encounter

Robert Packer
 Hospital
 06/25/2018

Outpatient

06/25/2018 Refill Kremer, Anna, LPN

SAYRE
 06/25/2018

Telephone Encounter - Kremer, Anna, LPN - 06/25/2018 12:31 PM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Signed Prescriptions Disp Refills
 • Methotrexate 2.5 MG Oral Tab 120 Tab 4
 Sig: Take 10 Tabs by mouth EVERY 7 DAYS.
 Authorizing Provider: MCDONALD JR, THOMAS J

sent to Clinic pharmacy via escribing
 Electronically signed by Kremer, Anna, LPN at 06/25/2018 12:31 PM EDT

SAYRE
06/21/2018

Progress Notes - Trecartin, Megan Nichole, MD - 06/21/2018 11:20 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 6/21/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Bee Sting

Stung Tuesday. Left side of face. Swelling

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female here for a same day appointment.

HPI

Bee sting

-On Monday while on vacation. She was on a boat on the St. Lawrence river when the bee got stuck in her glasses.

-Everytime she gets stung, her swelling gets worse.

-Would like epi pen.

-Took benadryl and yesterday when she got home, took leftover prednisone 40mg x 1.

-Swelling has mostly resolved now.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013

• **Anxiety**

- Attention deficit

- Back ache 3/18/2014

- Calcaneal spur 6/30/2008

- Cherry angioma 8/9/2016

- Cholecystitis

- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)

- **Depression** 1/20/2014

- Endocrine problem

- Epicondylitis elbow, medial 10/7/2008

- Fatty liver

- Fibromyalgia 8/20/2014

- Fractures

- Gastroparesis

irritable bowel syndrome

- GERD (gastroesophagea l reflux disease) 10/7/2008

- HTN (hypertension), benign 10/7/2008

- Hypertension

- Morbidly obese (HCC)

- Multinodular goiter

- Nontoxic multinodular goiter 1/18/2011

- Obesity

- Persistent mental disorders due to conditions classified elsewhere

- Physiologic ovarian cysts 10/4/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father

?Marfan's Syndrome

- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Prescriptions

Medication Sig

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1,000 mcg within a muscle EVERY THIRTY DAYS.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
- LEVONEST Oral Tab TAKE ONE TABLET BY MOUTH ONCE DAILY
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- Methotrexate 2.5 MG Oral Tab Take 10 Tabs by mouth EVERY 7 DAYS.
- ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.

- venlafaxine (EFEXOR), 75 mg Oral Capsule Take 75 mg by mouth EVERY DAY.
- Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap Take 50,000 Units by mouth EVERY 7 DAYS.

No current facility-adminis tered medications for this visit.

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Social History Main Topics

- Smoking status: Never Smoker
 - Smokeless tobacco: Never Used
 - Alcohol use No
 - Drug use: No
 - Sexual activity: Yes
- Partners: Male
Birth control/ protection: Pill, Condom
Comment: OCPs

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative for chills and fever.
Eyes: Negative for blurred vision, double vision and pain.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal : Positive for nausea (the next day after sting). Negative for constipation, diarrhea and vomiting.
Neurological: Negative for dizziness and headaches.

Objective

PHYSICAL EXAM:

VITALS: BP 110/82 (BP Location: Right arm, Patient Position: Sitting) | Pulse 56 | Temp 98.8 °F (37.1 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 285 lb 3.2 oz (129.4 kg) | SpO2 99% | BMI 39.78 kg/m² Body mass index is 39.78 kg/m².
Physical Exam
Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: Nose normal.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: Pupils are equal, round, and reactive to light.
Slight swelling at site of bee sting (between left nasal bridge and left eye)
Neck: Neck supple.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
No murmur heard.
Pulmonary/Chest: Effort normal. No respiratory distress. She has no wheezes.
Abdominal: Soft. She exhibits no distension. There is no tenderness.
Neurological: She is alert and oriented to person, place, and time. GCS score is 15.
Skin: Skin is warm and dry. She is not diaphoretic. No erythema.

Take benadryl at night. No need for prednisone at this time.
E905.3
2. Vitamin B12 deficiency, chronic. Status post gastric sleeve. 266.2 E53.8 IM Vitamin B12.

Plan
Patient Instructions
Pick up epi pen from pharmacy.

Take benadryl for the next couple of days at night to reduce swelling in the morning.
Follow up as previously scheduled.

Patient has been discussed with Dr. Gillan who agrees with the above assessment and plan.
Author: Megan Nichole Trecartin, MD 6/21/2018 11:52

Electronically signed by Trecartin, Megan Nichole, MD at 06/22/2018 7:34 AM EDT

Progress Notes - Gillan, Michael F, DO - 06/21/2018 11:20 AM EDT

Guthrie Clinic/RPH Supervising DO Documentation
Date of Service: 6/21/2018 B#: 340616

I discussed the patient with the resident. I agree with the assessment diagnostic and treatment plan as documented in the resident's note.
Michael F Gillan, DO
Supervising Physician
Department of Family Medicine

Electronically signed by Gillan, Michael F, DO at 06/22/2018 7:42 AM EDT
Nursing Note - Lantz, Tricia, LPN - 06/21/2018 11:20 AM EDT

Formatting of this note might be different from the original.
PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 6/21/2018

Chief Complaint
Patient presents with
• Bee Sting
Stung Tuesday. Left side of face. Swelling

B12 injection 1,000 mcg given in LD without incident.
Author: Tricia Lantz, LPN 6/21/2018 11:31

Electronically signed by Lantz, Tricia, LPN at 06/21/2018 11:46 AM EDT
Snyder-Sherman, Carolyn J, CRNP

PROCEED

Procedures

RPH MAIN OR

<u>Date</u>	<u>Procedure/Encounter Type [Code]</u>
05/24/2019	ARTHROSCOPY SHOULDER SUBACROMIAL DECOMPRESSION [29826]

Non-identified Provider

<u>Date</u>	<u>Procedure/Encounter Type [Code]</u>
06/06/2019	CRP SerPI-mCnc [1988-5]
06/06/2019	Comp Metab 2000 Pnl SerPI [24323-8]
06/06/2019	25(OH)D SerPI-mCnc [62292-8]
06/06/2019	ESR Bld Qn 15M [43402-7]
06/06/2019	CBC WITH DIFFERENTIAL [85025]
05/24/2019	SIGN PERMIT [553]
05/24/2019	PR INJ,ANES AGENT,BRACHIAL PLEXUS,SINGLE [64415]
05/24/2019	PR SONO GUIDE NEEDLE BIOPSY [76942]
05/24/2019	URINE PREGNANCY (POCT) [5960124]
05/17/2019	B-Hem Strep Throat Ql Cult [546-2]
05/15/2019	STREP A ANTIGEN (AMB POCT) [87880]
05/06/2019	Bas Metab 2000 Pnl SerPI [24321-2]
05/06/2019	CBC NO DIFFERENTIAL [85027]
05/02/2019	REFER TO SLEEP STUDY LAB [6507112]
04/18/2019	HC CT HEAD W/O CONTRAST [70450]
03/29/2019	REFER TO SLEEP STUDY LAB [6507112]
02/11/2019	HC ELBOW, 2 VIEWS [73070]
01/24/2019	VARICELLA ZOSTER ANTIBODY IGG [86787]
01/23/2019	HBV surface Ab Ser EIA-aCnc [5193-8]
01/17/2019	25(OH)D SerPI-mCnc [62292-8]
01/17/2019	ESR Bld Qn 15M [43402-7]
01/17/2019	CRP SerPI-mCnc [1988-5]
01/17/2019	Comp Metab 2000 Pnl SerPI [24323-8]
01/17/2019	CBC WITH DIFFERENTIAL [85025]
12/23/2018	HC MRI PELVIS W/O & W/CONTRAST [72197]
12/22/2018	Bacteria Ur Cult [630-4]
12/21/2018	URINE DIP MANUAL (AMB POCT) [81002]
11/14/2018	HC ULTRASOUND PELVIC/B-SCAN W/IMAGE DOC [76856]
11/12/2018	Comp Metab 2000 Pnl SerPI [24323-8]
11/12/2018	CBC WITH DIFFERENTIAL [85025]
11/09/2018	EMG/NCV [3188]
10/13/2018	ENA Ab Pnl Ser [43119-7]
10/13/2018	ANTI HISTONE ANTIBODY [89325]
10/13/2018	ANA TITER [86039]
09/26/2018	HC SHOULDER COMPLETE STUD [73030]
09/14/2018	ESR Bld Qn 15M [43402-7]
09/14/2018	Comp Metab 2000 Pnl SerPI [24323-8]
09/14/2018	CRP SerPI-mCnc [1988-5]
09/14/2018	CBC WITH DIFFERENTIAL [85025]
08/24/2018	HC FOOT,MINIMUM 3 VIEWS [73630]
08/16/2018	HC ULTRASOUND PELVIC/B-SCAN W/IMAGE DOC [76856]
08/14/2018	Folate+Vit B12 SerBld-Imp [49264-5]
08/10/2018	HC FINGER [73140]
07/11/2018	Bacteria Aspirate Anaerobe Cult [598-3]
07/10/2018	HC KNEE, 4 OR MORE VIEWS [73564]

		Narrative Text		
Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
COMPREHENSIVE METABOLIC PANEL	Routine	06/06/2019 12:57 PM EDT	Generalized abdominal pain Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
C-REACTIVE PROTEIN	Routine	06/06/2019 12:57 PM EDT	Generalized abdominal pain Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
VITAMIN D 25 HYDROXY (GUTHRIE)	Routine	06/06/2019 12:14 PM EDT	Low vitamin D level Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
SEDIMENTATION RATE	Routine	06/06/2019 11:37 AM EDT	Generalized abdominal pain Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
CBC WITH DIFFERENTIAL	Routine	06/06/2019 11:02 AM EDT	Generalized abdominal pain Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
SIGN PERMIT		05/24/2019 12:00 PM EDT		
PR SONO GUIDE NEEDLE BIOPSY	Routine	05/24/2019 7:41 AM EDT		Results for this procedure are in the results section
PR INJ,ANES AGENT,BRACHIAL PLEXUS,SINGLE	Routine	05/24/2019 7:41 AM EDT		Results for this procedure are in the results section
ARTHROSCOPY SHOULDER SUBACROMIAL DECOMPRESSION	Planned Trip to OR	05/24/2019 7:34 AM EDT	Impingement syndrome of left shoulder	
URINE PREGNANCY (POCT)	Routine	05/24/2019 6:30 AM EDT		Results for this procedure are in the results section

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
THROAT STREP SCREENING CULTURE	Routine	05/17/2019 11:07 AM EDT	Sore throat	Results for this procedure are in the EXHIBIT NO. B2F PAGE: 198 OF 309 results section
STREP A ANTIGEN (AMB POCT)	Routine	05/15/2019	Sore throat	Results for this procedure are in the results section
BASIC METABOLIC PANEL	STAT	05/06/2019 2:50 PM EDT		Results for this procedure are in the results section
CBC NO DIFFERENTIAL	STAT	05/06/2019 2:28 PM EDT		Results for this procedure are in the results section
REFER TO SLEEP STUDY LAB	Routine	05/02/2019	OSA (obstructive sleep apnea)	Results for this procedure are in the results section
CT HEAD WITHOUT IV CONTRAST	STAT	04/18/2019 3:52 PM EDT		Results for this procedure are in the results section
REFER TO SLEEP STUDY LAB	Routine	03/29/2019	OSA (obstructive sleep apnea)	Results for this procedure are in the results section
XR ELBOW 2 VIEWS RIGHT	Routine	02/11/2019 4:12 PM EST	Arthralgia of right upper arm	Results for this procedure are in the results section
VARICELLA ZOSTER ANTIBODY IGG	Routine	01/24/2019 4:39 PM EST	Annual physical exam	Results for this procedure are in the results section
HEPATITIS B SURFACE ANTIBODY	Routine	01/23/2019 11:33 AM EST	Annual physical exam	Results for this procedure are in the results section
VITAMIN D 25 HYDROXY (GUTHRIE)	Routine	01/17/2019 1:53 PM EST	Vitamin D deficiency	Results for this procedure are in the results section
SEDIMENTATION RATE	Routine	01/17/2019 1:46 PM EST	Immunosuppressio n due to drug therapy	Results for this procedure are in the results section
			Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section
COMPREHENSIVE METABOLIC PANEL	Routine	01/17/2019 1:45 PM EST	Immunosuppressio n due to drug therapy	Results for this procedure are in the results section

C-REACTIVE PROTEIN	Routine	01/17/2019 1:45 PM EST	Immunosuppression due to drug therapy	Results for this procedure are in the
			Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	results section
CBC WITH DIFFERENTIAL	Routine	01/17/2019 1:17 PM EST	Immunosuppression due to drug therapy	Results for this procedure are in the
			Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	results section
MR PELVIS W AND WO CONTRAST	Routine	12/23/2018 2:44 PM EST	Adnexal mass	Results for this procedure are in the
				results section
URINE CULTURE (C&S)	Routine	12/22/2018 1:58 PM EST	Dysuria	Results for this procedure are in the
				results section
URINE DIP MANUAL (AMB POCT)	Routine	12/21/2018	Dysuria	Results for this procedure are in the
				results section
US PELVIC COMPLETE WITH EV PROBE	Routine	11/14/2018 3:45 AM EST	Endometrioma of ovary	Results for this procedure are in the
				results section
COMPREHENSIVE METABOLIC PANEL	Routine	11/12/2018 1:04 PM EST		Results for this procedure are in the
				results section
CBC WITH DIFFERENTIAL	Routine	11/12/2018 12:37 PM EST		Results for this procedure are in the
				results section
EMG/NCV	Routine	11/09/2018	Numbness and tingling of right arm	Results for this procedure are in the
				results section
ANA TITER	Routine	10/13/2018 12:26 AM EDT	Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC)	Results for this procedure are in the
				results section
ANTI HISTONE ANTIBODY	Routine	10/13/2018 12:26 AM EDT	Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC)	Results for this procedure are in the
				results section

Procedure Name

Priority

Date/Time

Associated Diagnosis

Comments

ANTI NUCLEAR ANTIBODY	Routine	09/13/2018 10:32 AM EDT	Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC)	Results for this procedure are in the EXHIBIT NO. B2F PAGE: 200 OF 309 <u>results</u> section
XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)	Routine	09/26/2018 10:27 AM EDT	Acute pain of left shoulder	<u>Results</u> for this procedure are in the <u>results</u> section
SEDIMENTATION RATE	Routine	09/14/2018 12:48 PM EDT	Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC)	<u>Results</u> for this procedure are in the <u>results</u> section
C-REACTIVE PROTEIN	Routine	09/14/2018 12:30 PM EDT	Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC)	<u>Results</u> for this procedure are in the <u>results</u> section
COMPREHENSIVE METABOLIC PANEL	Routine	09/14/2018 12:30 PM EDT	Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC)	<u>Results</u> for this procedure are in the <u>results</u> section
CBC WITH DIFFERENTIAL	Routine	09/14/2018 12:06 PM EDT	Rheumatoid arthritis involving both hands with positive rheumatoid factor (HCC)	<u>Results</u> for this procedure are in the <u>results</u> section
XR FOOT MIN 3 VIEWS LEFT (STANDARD)	Routine	08/24/2018 5:16 PM EDT	Left foot pain	<u>Results</u> for this procedure are in the <u>results</u> section
US PELVIC COMPLETE WITH EV PROBE	Routine	08/16/2018 4:32 PM EDT	Cyst of right ovary	<u>Results</u> for this procedure are in the <u>results</u> section
VITAMIN B12 / FOLATE	Routine	08/14/2018 2:06 PM EDT	Vitamin B 12 deficiency	<u>Results</u> for this procedure are in the <u>results</u> section
XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD)	Routine	08/10/2018 3:37 PM EDT	Pain of right thumb	<u>Results</u> for this procedure are in the <u>results</u> section
ANAEROBIC CULTURE (C&S)	Routine	07/11/2018 8:19 AM EDT	Knee swelling	<u>Results</u> for this procedure are in the <u>results</u> section
XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)	Routine	07/10/2018 2:56 AM EDT	Acute pain of right knee	<u>Results</u> for this procedure are in the <u>results</u> section
PR ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/O US	Routine	07/06/2018 9:20 AM EDT	Knee swelling	<u>Results</u> for this procedure are in the <u>results</u> section

from 06/18/2018 to 06/27/2019

LABS

Laboratory Results

Date	Test
06/06/2019	Comp Metab 2000 Pnl SerPI
	A/G Ratio Value: 1.2 ratio Ref Range: 0.8 - 2.0 ratio Text: A/G Ratio 1.2 0.8 - 2.0 ratio GUTHRIE MEDICAL GROUP LABORATORY
	ALP SerPI-cCnc Value: 51 U/L Ref Range: 40 - 150 U/L Text: Alkaline Phosphatase 51 40 - 150 U/L GUTHRIE MEDICAL GROUP LABORATORY
	ALT SerPI-cCnc Value: 27 U/L Ref Range: 9 - 52 U/L Text: ALT 27 9 - 52 U/L GUTHRIE MEDICAL GROUP LABORATORY
	AST SerPI-cCnc Value: 29 U/L Ref Range: 15 - 46 U/L Text: AST 29 15 - 46 U/L GUTHRIE MEDICAL GROUP LABORATORY
	Albumin SerPI-mCnc Value: 4.1 g/dl Ref Range: 3.5 - 5.0 g/dl Text: Albumin 4.1 3.5 - 5.0 g/dl GUTHRIE MEDICAL GROUP LABORATORY
	Anion Gap Value: 8 mmol/L Ref Range: 3 - 11 mmol/L Text: Anion Gap 8 3 - 11 mmol/L GUTHRIE MEDICAL GROUP LABORATORY
	BUN SerPI-mCnc Value: 13 mg/dl Ref Range: 7 - 17 mg/dl Text: BUN 13 7 - 17 mg/dl GUTHRIE MEDICAL GROUP LABORATORY
	BUN/Creatinine Ratio Value: 16 RATIO Ref Range: 6 - 22 RATIO Text: BUN/Creatinine Ratio 16 6 - 22 RATIO GUTHRIE MEDICAL GROUP LABORATORY
	Bilirub SerPI-mCnc Value: 0.3 MG/DL Ref Range: 0.0 - 1.1 MG/DL Text: Total Bilirubin 0.3 0.0 - 1.1 MG/DL GUTHRIE MEDICAL GROUP LABORATORY

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Date	Test	EXHIBIT NO. B2F PAGE: 202 OF 309																																																															
	CO2 SerPI-sCnc	Value: 26 mmol/L Ref Range: 22 - 30 mmol/L Text: CO2 26 22 - 30 mmol/L GUTHRIE MEDICAL GROUP LABORATORY																																																															
	Calcium SerPI-mCnc	Value: 8.9 mg/dl Ref Range: 8.3 - 10.1 mg/dl Text: Calcium 8.9 8.3 - 10.1 mg/dl GUTHRIE MEDICAL GROUP LABORATORY																																																															
	Chloride SerPI-sCnc	Value: 103 mmol/L Ref Range: 98 - 107 mmol/L Text: Chloride 103 98 - 107 mmol/L GUTHRIE MEDICAL GROUP LABORATORY																																																															
	Associated Procedure: Comp Metab 2000 Pnl SerPI	Text: COMPREHENSIVE METABOLIC PANEL (06/06/2019 12:57 PM EDT) <table><tr><th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr><tr><td>Sodium</td><td>137</td><td>134 - 145 mmol/L</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Potassium</td><td>4.5</td><td>3.5 - 5.1 mmol/L</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Chloride</td><td>103</td><td>98 - 107 mmol/L</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>CO2</td><td>26</td><td>22 - 30 mmol/L</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Calcium</td><td>8.9</td><td>8.3 - 10.1 mg/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Albumin</td><td>4.1</td><td>3.5 - 5.0 g/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>BUN</td><td>13</td><td>7 - 17 mg/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Creatinine</td><td>0.8</td><td>0.7 - 1.2 mg/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Glucose</td><td>84</td><td>70 - 99 mg/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Total Protein</td><td>7.4</td><td>6.3 - 8.2 g/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr><tr><td>Total Bilirubin</td><td>0.3</td><td>0.0 - 1.1 MG/DL</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr></table>				Component	Value	Ref Range	Performed At	Pathologist Signature	Sodium	137	134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY		Potassium	4.5	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY		Chloride	103	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY		CO2	26	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY		Calcium	8.9	8.3 - 10.1 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY		Albumin	4.1	3.5 - 5.0 g/dl	GUTHRIE MEDICAL GROUP LABORATORY		BUN	13	7 - 17 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY		Creatinine	0.8	0.7 - 1.2 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY		Glucose	84	70 - 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY		Total Protein	7.4	6.3 - 8.2 g/dl	GUTHRIE MEDICAL GROUP LABORATORY		Total Bilirubin	0.3	0.0 - 1.1 MG/DL	GUTHRIE MEDICAL GROUP LABORATORY	
Component	Value	Ref Range	Performed At	Pathologist Signature																																																													
Sodium	137	134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY																																																														
Potassium	4.5	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY																																																														
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Total Bilirubin	0.3	0.0 - 1.1 MG/DL	GUTHRIE MEDICAL GROUP LABORATORY																																																														

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Test				EXHIBIT NO. B2F PAGE: 203 OF 309	
AST 20 15 - 46 U/L				GUTHRIE MEDICAL GROUP LABORATORY	
ALT 27 9 - 52 U/L				GUTHRIE MEDICAL GROUP LABORATORY	
Alkaline Phosphatase 51 40 - 150 U/L				GUTHRIE MEDICAL GROUP LABORATORY	
eGFR >60 See Interpretation Below ml/min/1.73ml Sq				GUTHRIE MEDICAL GROUP LABORATORY	
Comment:					
Estimated GFR Interpretation: Above 60ml/min/1.73m2 = Normal Renal Function 30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/mrd-study-equation					
BUN/Creatinine Ratio 16 6 - 22 RATIO				GUTHRIE MEDICAL GROUP LABORATORY	
Anion Gap 8 3 - 11 mmol/L				GUTHRIE MEDICAL GROUP LABORATORY	
A/G Ratio 1.2 0.8 - 2.0 ratio				GUTHRIE MEDICAL GROUP LABORATORY	
Blood				Specimen	
Performing Organization		Address		City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY		1 GUTHRIE SQUARE		SAYRE, PA 18840	570-887-4719
Creat SerPl-mCnc					
Value: 0.8 mg/dl					
Ref Range: 0.7 - 1.2 mg/dl					
Text:					
Creatinine 0.8 0.7 - 1.2 mg/dl GUTHRIE MEDICAL GROUP LABORATORY					
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Date	Test	Value	Ref Range	Text	Pathologist Signature
	GFR/BSA, pred SerPI MDRD-ArVRat	>60	See Interpretation Below ml/min/1.73ml Sq	See Interpretation Below ml/min/1.73ml Sq	GUTHRIE MEDICAL GROUP LABORATORY
				Estimated GFR Interpretation: Above 60ml/min/1.73m2 = Normal Renal Function 30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/mrd-study-equation	
	Glucose SerPI-mCnc	84 mg/dl	70 - 99 mg/dl	Glucose 84 70 - 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY
	Potassium SerPI-sCnc	4.5 mmol/L	3.5 - 5.1 mmol/L	Potassium 4.5 3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
	Prot SerPI-mCnc	7.4 g/dl	6.3 - 8.2 g/dl	Total Protein 7.4 6.3 - 8.2 g/dl	GUTHRIE MEDICAL GROUP LABORATORY
	Sodium SerPI-sCnc	137 mmol/L	134 - 145 mmol/L	Sodium 137 134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
06/06/2019	CRP SerPI-mCnc				
	CRP SerPI-mCnc	0.80 mg/dl	<1.00 mg/dl	C-Reactive Protein 0.80 <1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY
	Associated Procedure: CRP SerPI-mCnc	Text: C-REACTIVE PROTEIN (06/06/2019 12:57 PM EDT)			
		Component	Value	Ref Range	Performed At
		C-Reactive Protein	0.80	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY
		Specimen			
		Blood			
		Performing Organization	Address	City/State/Zipcode	Phone Number
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
06/06/2019	25(OH)D SerPI-mCnc				
	25(OH)D SerPI-mCnc	32.0 ng/ml	32.0 - 100.0 ng/ml		

Date	Test	GUTHRIE MEDICAL GROUP LABORATORY			
	Associated Procedure: 25(OH)D SerPI-mCnc	Text: VITAMIN D 25 HYDROXY (GUTHRIE) (06/06/2019 12:14 PM EDT) Component Value Ref Range Performed At Pathologist Signature Vitamin D 25 32.0 32.0 - 100.0 GUTHRIE MEDICAL GROUP HYDROXY ng/ml LABORATORY Specimen Blood Narrative Performed At Interpretation: GUTHRIE MEDICAL GROUP LABORATORY <20 ng/ml Deficiency 20-<30 ng/ml Insufficiency 32-100 ng/ml Sufficiency >100 ng/ml Potential Toxicity Performing Organization Address City/State/Zipcode Phone Number GUTHRIE MEDICAL GROUP 1 GUTHRIE SAYRE, PA 18840 570-887-4719 LABORATORY SQUARE			
06/06/2019	ESR Bld Qn 15M				
	ESR Bld Qn 15M	Value: 11 MM/HR Ref Range: 0 - 20 MM/HR Text: ESR 11 0 - 20 MM/HR GUTHRIE MEDICAL GROUP LABORATORY			
	Associated Procedure: ESR Bld Qn 15M	Text: SEDIMENTATION RATE (06/06/2019 11:37 AM EDT) Component Value Ref Range Performed At Pathologist Signature ESR 11 0 - 20 GUTHRIE MEDICAL GROUP MM/HR LABORATORY Specimen Blood Performing Organization Address City/State/Zipcode Phone Number GUTHRIE MEDICAL GROUP 1 GUTHRIE SAYRE, PA 18840 570-887-4719 LABORATORY SQUARE			
06/06/2019	85025				
	Associated Procedure: #Result159007916	Text: CBC WITH DIFFERENTIAL (06/06/2019 11:02 AM EDT)			

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
	Procedure					
		WBC Count	8.97	3.98 - 10.04 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		RBC Count	4.64	3.93 - 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hemoglobin	13.5	11.2 - 15.7 G/DL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hematocrit	41.7	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY	
		MCV	89.9	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY	
		MCH	29.1	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY	
		MCHC	32.4	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Platelet Count	348	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		MPV	9.4	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY	
		RDW	13.1	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil %	60.8	34.0 - 71.1 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte %	25.0	19.3 - 51.7 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte %	10.1	4.7 - 12.5 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Eosinophil %	3.1	0.7 - 5.8 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil %	0.6	0.1 - 1.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
		nRBC %	0.0	0.0 - 0.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil #	5.45	1.56 - 6.13 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte #	2.24	1.18 - 3.74 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte #	0.91	0.24 - 0.86 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		(H)				
		Eosinophil #	0.28	0.04 - 0.36 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil #	0.05	0.01 - 0.08 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Immature Gran %	0.4	0.0 - 0.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Immature Gran #	0.04	0.00 - 0.03 (H) K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		NRBC #	0.00	0.00 - 0.12 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen				
		Blood				
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719	
	Basophils # Bld Auto	Value: 0.05 K/UL Ref Range: 0.01 - 0.08 K/UL Text: Basophil # 0.05 0.01 - 0.08 K/UL				
				GUTHRIE MEDICAL GROUP LABORATORY		

Date	Test	
	Basophils NFr Bld Auto	Value: 0.6 % Ref Range: 0.1 - 1.2 % Text: Basophil % 0.6 0.1 - 1.2 % GUTHRIE MEDICAL GROUP LABORATORY
	Eosinophil # Bld Auto	Value: 0.28 K/UL Ref Range: 0.04 - 0.36 K/UL Text: Eosinophil # 0.28 0.04 - 0.36 K/UL GUTHRIE MEDICAL GROUP LABORATORY
	Eosinophil NFr Bld Auto	Value: 3.1 % Ref Range: 0.7 - 5.8 % Text: Eosinophil % 3.1 0.7 - 5.8 % GUTHRIE MEDICAL GROUP LABORATORY
	Hct VFr Bld Auto	Value: 41.7 % Ref Range: 34.1 - 44.9 % Text: Hematocrit 41.7 34.1 - 44.9 % GUTHRIE MEDICAL GROUP LABORATORY
	Hgb Bld-mCnc	Value: 13.5 G/DL Ref Range: 11.2 - 15.7 G/DL Text: Hemoglobin 13.5 11.2 - 15.7 G/DL GUTHRIE MEDICAL GROUP LABORATORY
	Imm Granulocytes # Bld Auto	Value: 0.04 K/uL Ref Range: 0.00 - 0.03 K/uL Interpretation: H Text: Immature Gran # 0.04 0.00 - 0.03 K/uL GUTHRIE MEDICAL GROUP LABORATORY (H)
	Imm Granulocytes NFr Bld Auto	Value: 0.4 % Ref Range: 0.0 - 0.4 % Text: Immature Gran % 0.4 0.0 - 0.4 % GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes # Bld Auto	Value: 2.24 K/UL Ref Range: 1.18 - 3.74 K/UL Text: Lymphocyte # 2.24 1.18 - 3.74 K/UL GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes NFr Bld Auto	Value: 25.0 % Ref Range: 19.3 - 51.7 % Text: Lymphocyte % 25.0 19.3 - 51.7 % GUTHRIE MEDICAL GROUP LABORATORY
	MCH RBC Qn Auto	Value: 29.1 PG Ref Range: 25.6 - 32.2 PG Text: MCH 29.1 25.6 - 32.2 PG GUTHRIE MEDICAL GROUP LABORATORY
	MCHC RBC Auto-mCnc	Value: 32.4 g/dL Ref Range: 32.2 - 35.5 g/dL Text: MCHC 32.4 32.2 - 35.5 g/dL GUTHRIE MEDICAL GROUP LABORATORY
	MCV RBC Auto	Value: 89.9 FL Ref Range: 79.4 - 94.8 FL Text: MCV 89.9 79.4 - 94.8 FL GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	Value: 0.91 K/UL Ref Range: 0.24 - 0.86 K/UL Interpretation: H Text: Monocyte # 0.91 0.24 - 0.86 K/UL GUTHRIE MEDICAL GROUP LABORATORY (H)
	Monocytes NFr Bld Auto	Value: 10.1 % Ref Range: 4.7 - 12.5 % Text: Monocyte % 10.1 4.7 - 12.5 % GUTHRIE MEDICAL GROUP LABORATORY

Date	Test	
	Neutrophils # Bld Auto	Value: 5.45 K/UL Ref Range: 1.56 - 6.13 K/UL Text: Neutrophil # 5.45 1.56 - 6.13 K/UL GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils NFr Bld Auto	Value: 60.8 % Ref Range: 34.0 - 71.1 % Text: Neutrophil % 60.8 34.0 - 71.1 % GUTHRIE MEDICAL GROUP LABORATORY
	PMV Bld Auto	Value: 9.4 FL Ref Range: 9.4 - 12.3 FL Text: MPV 9.4 9.4 - 12.3 FL GUTHRIE MEDICAL GROUP LABORATORY
	Platelet # Bld Auto	Value: 348 K/uL Ref Range: 182 - 369 K/uL Text: Platelet Count 348 182 - 369 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	RBC # Bld Auto	Value: 4.64 M/UL Ref Range: 3.93 - 5.22 M/UL Text: RBC Count 4.64 3.93 - 5.22 M/UL GUTHRIE MEDICAL GROUP LABORATORY
	RDW RBC Auto-Rto	Value: 13.1 % Ref Range: 11.7 - 14.4 % Text: RDW 13.1 11.7 - 14.4 % GUTHRIE MEDICAL GROUP LABORATORY
	WBC nRBC cor # Bld Auto	Value: 8.97 K/uL Ref Range: 3.98 - 10.04 K/uL Text: WBC Count 8.97 3.98 - 10.04 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	nRBC # Bld Auto	Value: 0.00 K/uL Ref Range: 0.00 - 0.12 K/uL Text: NRBC # 0.00 0.00 - 0.12 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	nRBC/100 WBC Bld Auto-Rto	Value: 0.0 % Ref Range: 0.0 - 0.2 % Text: nRBC % 0.0 0.0 - 0.2 % GUTHRIE MEDICAL GROUP LABORATORY
05/24/2019	553	
	Associated Procedure: #Result159007911 Procedure	
	Unknown	Text: SIGN PERMIT (05/24/2019 12:00 PM EDT) Narrative This result has an attachment that is not available.
05/24/2019	29394	
	Associated Procedure: #Result158999163 Procedure	
	Unknown	Text: Nerve Block (05/24/2019 7:41 AM EDT) Narrative Chopra, Nitin, MD 5/24/2019 7:42 AM Nerve Block Date/Time: 5/24/2019 7:34 AM Performed by: Chopra, Nitin, MD Authorized by: Chopra, Nitin, MD

Date	Test
	<p>Universal protocol</p> <p>Consent obtained: Written</p> <p>Consent provided by: Patient -</p> <p>Risks/benefits discussed with: Patient -</p> <p>Time out performed: Yes</p> <p>Consents match procedure: Yes</p> <p>Pre-Procedure</p> <p>Indications: post-op pain management</p> <p>Preadmission anticoagulation therapy:</p> <p>Location</p> <p>Body area: Upper extremity</p> <p>Upper Extremity: Interscalene</p> <p>Sedation/Analgesia</p> <p>Yes</p> <p>Level of sedation:</p> <p>Sedation type: anxiolysis</p> <p>Sedation: Midazolam and see MAR for details</p> <p>Vital signs monitored during sedation Vital signs monitored during sedation</p> <p>Procedure Details</p> <p>Preparation: Patient was prepped and draped in usual sterile fashion</p> <p>Prep Solution: Chloraprep</p> <p>Patient position: Beach chair</p> <p>Skin Infiltration Drug: lidocaine 1%</p> <p>Needle gauge: 22 G</p> <p>Needle type: Echogenic</p> <p>Needle length(cm): 5.0</p> <p>Location technique: Ultrasound guidance</p> <p>Local anesthetic: Ropivacaine 0.5%</p> <p>Anesthetic total (ml): 25</p> <p>Injection Made Incrementally in mL: 2</p> <p>Post procedure</p> <p>Outcome/Complications: Positive block</p> <p>Patient tolerance: Patient tolerated the procedure well with no immediate complications</p>

Date	Test				
		Vitals monitored during the procedure: Patient observed			
		Comments			
05/24/2019	5960124				
	Associated Procedure: #Result158222540 Procedure	Text: URINE PREGNANCY (POCT) (05/24/2019 6:30 AM EDT)			
		Component	Value	Ref Range	Performed At
		Urine Pregnancy Test (POCT)	negative		POINT OF CARE TESTING
		Qualitative Urine HCG Internal Control (POCT)	acceptable		POINT OF CARE TESTING
		Comment: Performed at: Robert Packer Hospital POCT Dilip Gupta MD, Laboratory Medical Director 1 Guthrie Square Sayre, PA 18840			
		Performing Organization	Specimen Address	City/State/Zipcode	Phone Number
		POINT OF CARE TESTING			
	Qualitative Urine HCG Internal Control (POCT)	Value: acceptable Text: Qualitative Urine HCG Internal Control (POCT)			
			acceptable		POINT OF CARE TESTING
		Comment: Performed at: Robert Packer Hospital POCT Dilip Gupta MD, Laboratory Medical Director 1 Guthrie Square Sayre, PA 18840			
	Urine Pregnancy Test (POCT)	Value: negative Text: Urine Pregnancy Test (POCT)			
			negative		POINT OF CARE TESTING
05/17/2019	B-Hem Strep Throat QI Cult				
	Associated Procedure: B-Hem Strep Throat QI Cult	Text: THROAT STREP SCREEN CULTURE (05/17/2019 11:11 AM EDT)			
		Component	Value	Ref Range	Performed At
		Throat Strep Screen Culture	No pathogenic beta hemolytic Streptococci cultured		GUTHRIE MEDICAL GROUP LABORATORY
		Specimen Throat			
		Performing Organization	Address	City/State/Zipcode	Phone Number
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
	Bacteria Throat Cult	Value: No pathogenic beta hemolytic Streptococci cultured Text: Throat Strep Screen No pathogenic beta hemolytic Streptococci cultured			
				GUTHRIE MEDICAL GROUP LABORATORY	
05/15/2019	87880				
	Associated Procedure: #Result158222529	Text: STREP A ANTIGEN (AMB POCT) (05/15/2019)			

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
	Procedure	Strep A Antigen (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	EXHIBIT NO: B21 PAGE: 211 OF 309
		Control Line	Present	Present	GUTHRIE CLINIC POCT	
		Strep A Antigen Confirm (POCT)	Yes, Sent for Confirmation		GUTHRIE CLINIC POCT	
		Lot Number	191127		GUTHRIE CLINIC POCT	
		Expiration Date	8/31/20		GUTHRIE CLINIC POCT	
		Specimen				
		Performing Organization	Address	City/State/Zip	code	Phone Number
		GUTHRIE CLINIC POCT	1 Guthrie Square	Sayre, PA	18840	
	Control Line	Value: Present Ref Range: Present Text: Control Line Present Present GUTHRIE CLINIC POCT				
	Expiration Date	Value: 8/31/20 Text: Expiration Date 8/31/20 GUTHRIE CLINIC POCT				
	Lot Number	Value: 191127 Text: Lot Number 191127 GUTHRIE CLINIC POCT				
	Strep A Antigen (POCT)	Value: Negative Ref Range: Negative Text: Strep A Antigen (POCT) Negative Negative GUTHRIE CLINIC POCT				
	Strep A Antigen Confirm (POCT)	Value: Yes, Sent for Confirmation Text: Strep A Antigen Confirm (POCT) Yes, Sent for Confirmation GUTHRIE CLINIC POCT				
05/06/2019	Bas Metab 2000 Pnl SerPI					
	Anion Gap	Value: 8 mmol/L Ref Range: 3 - 11 mmol/L Text: Anion Gap 8 3 - 11 mmol/L GUTHRIE MEDICAL GROUP LABORATORY				
	BUN SerPI-mCnc	Value: 11 mg/dl Ref Range: 7 - 17 mg/dl Text: BUN 11 7 - 17 mg/dl GUTHRIE MEDICAL GROUP LABORATORY				
	BUN/Creatinine Ratio	Value: 16 RATIO Ref Range: 6 - 22 RATIO Text: BUN/Creatinine Ratio 16 6 - 22 RATIO GUTHRIE MEDICAL GROUP LABORATORY				
	Associated Procedure: Bas Metab 2000 Pnl SerPI	Text: BASIC METABOLIC PANEL (05/06/2019 2:50 PM EDT)				
		Component	Value	Ref Range	Performed At	Pathologist Signature
		Glucose	82	70 - 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	535
		BUN	11	7 - 17 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Creatinine	0.7	0.7 - 1.2 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	

Date	Test					
		Sodium	130	131 - 145 mmol/L	GUTHRIE MEDICAL GROUP	LABORATORY
		Potassium	4.3	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP	LABORATORY
		Chloride	102	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP	LABORATORY
		CO2	29	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP	LABORATORY
		Calcium	9.0	8.3 - 10.1 mg/dl	GUTHRIE MEDICAL GROUP	LABORATORY
		eGFR	>60	See Interpretation	GUTHRIE MEDICAL GROUP	LABORATORY
			Comment:	Below ml/min/1.73m ² Sq	GUTHRIE MEDICAL GROUP	LABORATORY
			<p>Estimated GFR Interpretation:</p> <p>Above 60ml/min/1.73m² = Normal Renal Function</p> <p>30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease</p> <p>15-29 ml/min/1.73m² = Stage 4 Chronic Kidney Disease</p> <p>Less than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease</p> <p>The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:</p> <p>https://www.kidney.org/content/mrd-study-equation</p>			
		BUN/Creatinine Ratio	16	6 - 22 RATIO	GUTHRIE MEDICAL GROUP	LABORATORY
		Anion Gap	8	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP	LABORATORY
		Specimen				
		Blood				
		Performing Organization	Address	City/State/Zipcode	Phone	
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719	536ber

CO2 SerPI-sCnc

Value: 29 mmol/L**Ref Range:** 22 - 30 mmol/L**Text:**

CO2 29 22 - 30 mmol/L GUTHRIE MEDICAL GROUP LABORATORY

Calcium SerPI-mCnc

Value: 9.0 mg/dl**Ref Range:** 8.3 - 10.1 mg/dl**Text:**

Calcium 9.0 8.3 - 10.1 mg/dl GUTHRIE MEDICAL GROUP LABORATORY

Chloride SerPI-sCnc

Value: 102 mmol/L**Ref Range:** 98 - 107 mmol/L**Text:**

Chloride 102 98 - 107 mmol/L GUTHRIE MEDICAL GROUP LABORATORY

Creat SerPI-mCnc

Value: 0.7 mg/dl**Ref Range:** 0.7 - 1.2 mg/dl**Text:**

Creatinine 0.7 0.7 - 1.2 mg/dl GUTHRIE MEDICAL GROUP LABORATORY

GFR/BSA.prd SerPI
MDRD-ArVRat**Value:** >60**Ref Range:** See Interpretation Below ml/min/1.73ml Sq**Text:**

eGFR>60

See Interpretation GUTHRIE MEDICAL
Below ml/min/1.73ml GROUP
Sq LABORATORY

Comment:

Estimated GFR Interpretation:

Above 60ml/min/1.73m2 = Normal Renal
Function30-59 ml/min/1.73m2 = Stage 3 Chronic
Kidney Disease15-29 ml/min/1.73m2 = Stage 4 Chronic
Kidney DiseaseLess than 15 ml/min/1.73m2 = Stage 5
Chronic Kidney DiseaseThe GFR value is calculated using the
Modification of Diet in Renal Disease
(MDRD) Study Equation which can be
found at:<https://www.kidney.org/content/mrd-study-equation>

Glucose SerPI-mCnc

Value: 82 mg/dl**Ref Range:** 70 - 99 mg/dl**Text:**

Glucose 82 70 - 99 mg/dl GUTHRIE MEDICAL GROUP LABORATORY

Potassium SerPI-sCnc

Value: 4.3 mmol/L**Ref Range:** 3.5 - 5.1 mmol/L**Text:**

Potassium 4.3 3.5 - 5.1 mmol/L GUTHRIE MEDICAL GROUP LABORATORY

Sodium SerPI-sCnc

Value: 139 mmol/L**Ref Range:** 134 - 145 mmol/L**Text:**

Sodium 139 134 - 145 mmol/L GUTHRIE MEDICAL GROUP LABORATORY

05/06/2019

85027Associated Procedure:
#Result158194701**Text:**

CBC NO DIFFERENTIAL (05/06/2019 2:28 PM EDT)

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
<div>Case 6:21-cv-06189-LGF Document 1-1 Filed 08/27/23 Page 542 of 1112</div> <div>EXHIBIT NO: B29</div> <div>PAGE: 214 OF 309</div>						
	Procedure	WBC Count	9.23	3.98 - 10.04 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Comment: Methodology was changed 1/3/2019. Please note updated reference range and units.				
		RBC Count	4.57	3.93 - 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hemoglobin	13.5	11.2 - 15.7 G/DL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hematocrit	41.1	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY	
		MCV	89.9	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY	
		MCH	29.5	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY	
		MCHC	32.8	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Platelet Count	345	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		MPV	9.4	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY	
		RDW	13.0	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen				
		Blood				
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719	
	Hct VFr Bld Auto	Value: 41.1 % Ref Range: 34.1 - 44.9 % Text: Hematocrit 41.1 34.1 - 44.9 % GUTHRIE MEDICAL GROUP LABORATORY				
	Hgb Bld-mCnc	Value: 13.5 G/DL Ref Range: 11.2 - 15.7 G/DL Text: Hemoglobin 13.5 11.2 - 15.7 G/DL GUTHRIE MEDICAL GROUP LABORATORY				
	MCH RBC Qn Auto	Value: 29.5 PG Ref Range: 25.6 - 32.2 PG Text: MCH 29.5 25.6 - 32.2 PG GUTHRIE MEDICAL GROUP LABORATORY				
	MCHC RBC Auto-mCnc	Value: 32.8 g/dL Ref Range: 32.2 - 35.5 g/dL Text: MCHC 32.8 32.2 - 35.5 g/dL GUTHRIE MEDICAL GROUP LABORATORY				
	MCV RBC Auto	Value: 89.9 FL Ref Range: 79.4 - 94.8 FL Text: MCV 89.9 79.4 - 94.8 FL GUTHRIE MEDICAL GROUP LABORATORY				

Date	Test	
	PMV Bld Auto	Value: 9.4 FL Ref Range: 9.4 - 12.3 FL Text: MPV 9.4 9.4 - 12.3 FL GUTHRIE MEDICAL GROUP LABORATORY
	Platelet # Bld Auto	Value: 345 K/uL Ref Range: 182 - 369 K/uL Text: Platelet Count 345 182 - 369 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	RBC # Bld Auto	Value: 4.57 M/UL Ref Range: 3.93 - 5.22 M/UL Text: RBC Count 4.57 3.93 - 5.22 M/UL GUTHRIE MEDICAL GROUP LABORATORY
	RDW RBC Auto-Rto	Value: 13.0 % Ref Range: 11.7 - 14.4 % Text: RDW 13.0 11.7 - 14.4 % GUTHRIE MEDICAL GROUP LABORATORY
	WBC # Bld Auto	Value: 9.23 K/uL Ref Range: 3.98 - 10.04 K/uL Text: WBC 9.23 3.98 - GUTHRIE MEDICAL Count Comment: 10.04 K/uL GROUP LABORATORY Methodology was changed 1/3/2019. Please note updated reference range and units.
05/02/2019	6507112	
	Associated Procedure: #Result154399052 Procedure	
	Unknown	Text: REFER TO SLEEP STUDY LAB (05/02/2019) Specimen Narrative This result has an attachment that is not available. Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie. Performed At
04/18/2019	36376	
	Associated Procedure: #Result157252875 Procedure	
	Unknown	Text: CT HEAD WITHOUT IV CONTRAST (04/18/2019 3:52 PM EDT) Specimen Impressions IMPRESSION: No acute intracranial findings. Urgency: Routine. This is a routine medical imaging report. Recommendation: No specific imaging recommendation. Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM Performed At

Date	Test
	<div data-bbox="267 31 1356 73">Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 544 of 1112</div> <div data-bbox="917 42 1031 73">Narrative</div> <div data-bbox="1250 42 1599 115">EXHIBIT NO. B2F PAGE: 216 OF 309</div> <div data-bbox="1429 42 1599 73">Performed At</div> <p>Procedure(s): CT HEAD WITHOUT IV CONTRAST</p> <p>Date of service: 4/18/2019 3:29 PM</p> <p>Provided clinical information: 42 years, Female, "Headache, acute, norm neuro exam: sent by family practice for CT"</p> <p>Procedure and materials: Standard protocol.</p> <p>Contrast: None.</p> <p>Comparison studies: 7/17/2008.</p> <p>Observations:</p> <p>There is no midline shift or mass effect. CSF spaces appear normal for age. No pathologic fluid collections are seen. No acute intracranial hemorrhage is noted.</p> <p>The gray-white matter differentiation is well preserved. There is no evidence for an acute transcortical or vascular territorial infarct.</p> <p>There is no depressed calvarial fracture. The skull base and surrounding soft tissues appear unremarkable.</p> <div data-bbox="966 966 1161 997">Procedure Note</div> <p>Interface, Rad Results - 04/18/2019 3:54 PM EDT</p> <p>Procedure(s): CT HEAD WITHOUT IV CONTRAST</p> <p>Date of service: 4/18/2019 3:29 PM</p> <p>Provided clinical information: 42 years, Female, "Headache, acute, norm neuro exam: sent by family practice for CT"</p> <p>Procedure and materials: Standard protocol.</p> <p>Contrast: None.</p> <p>Comparison studies: 7/17/2008.</p> <p>Observations:</p> <p>There is no midline shift or mass effect. CSF spaces appear normal for age. No pathologic fluid collections are seen. No acute intracranial hemorrhage is noted.</p> <p>The gray-white matter differentiation is well preserved. There is no evidence for an acute transcortical or vascular territorial infarct.</p> <p>There is no depressed calvarial fracture. The skull base and</p>

surrounding soft tissues appear unremarkable.

IMPRESSION

IMPRESSION:

No acute intracranial findings.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM

03/29/2019	6507112	
	Associated Procedure: #Result150855810 Procedure	
	Unknown	<p>Text: REFER TO SLEEP STUDY LAB (03/29/2019)</p> <p style="text-align: center;">Specimen Narrative</p> <p style="text-align: right;">Performed At</p> <p>This result has an attachment that is not available.</p> <p>Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie.</p>
02/11/2019	34834	
	Associated Procedure: #Result154399047 Procedure	
	Unknown	<p>Text: XR ELBOW 2 VIEWS RIGHT (02/11/2019 4:12 PM EST)</p> <p style="text-align: center;">Specimen Impressions</p> <p style="text-align: right;">Performed At</p> <p>Impression:</p> <p>Unremarkable exam.</p> <p>Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM</p>

Date	Test	Narrative	EXHIBIT NO. B2F PAGE: 218 OF 309
		<p>Procedure(s): XR ELBOW 2 VIEWS RIGHT</p> <p>Date of service: 2/7/2019 3:36 PM</p> <p>Provided clinical information: 42 years, Female, "pain"</p> <p>Procedure and materials: 2 images of the right elbow were obtained.</p> <p>Comparison studies: None.</p> <p>Observations:</p> <p>No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.</p> <p style="text-align: center;">Procedure Note</p> <p>Interface, Rad Results - 02/11/2019 4:15 PM EST</p> <p>Procedure(s): XR ELBOW 2 VIEWS RIGHT</p> <p>Date of service: 2/7/2019 3:36 PM</p> <p>Provided clinical information: 42 years, Female, "pain"</p> <p>Procedure and materials: 2 images of the right elbow were obtained.</p> <p>Comparison studies: None.</p> <p>Observations:</p> <p>No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.</p> <p>IMPRESSION</p> <p>Impression:</p> <p>Unremarkable exam.</p> <p>Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM</p>	
01/24/2019	86787		
	Associated Procedure: #Result150855807	Text: VARICELLA ZOSTER ANTIBODY IGG (01/24/2019 4:39 PM EST)	

Date	Test	Variable Z Score	Comment:	QUEST DIAGNOSTICS										
		Ab Igg	<p>INDEX VALUE RESULTS INTERPRETATION</p> <p>-----</p> <p><135.00 N egative Negat ive Result. Antibody not detected</p> <p>135.00-164.99 E quivocal Equivocal result. Consider re-testing on a new specimen</p> <p>>=165.00 Positive Samp le is considered positive for IgG antibodies to VZV virus</p> <p>A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection.</p>											
01/23/2019	HBV surface Ab Ser EIA-aCnc													
	Associated Procedure: HBV surface Ab Ser EIA-aCnc	<p>Text: HEPATITIS B SURFACE ANTIBODY (01/23/2019 11:33 AM EST)</p> <table><thead><tr><th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr></thead><tbody><tr><td>Hepatitis B Surface Antibody</td><td>274.00</td><td>See Result Interpretation for Immune Status mIU/ml</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr></tbody></table> <p>Specimen Blood specimen (specimen) - Blood - Veni</p>			Component	Value	Ref Range	Performed At	Pathologist Signature	Hepatitis B Surface Antibody	274.00	See Result Interpretation for Immune Status mIU/ml	GUTHRIE MEDICAL GROUP LABORATORY	
Component	Value	Ref Range	Performed At	Pathologist Signature										
Hepatitis B Surface Antibody	274.00	See Result Interpretation for Immune Status mIU/ml	GUTHRIE MEDICAL GROUP LABORATORY											

Date	Test	Narrative	Result	Performed At										
		Vitros Test Result Interpretation <5.00 mIU/ml Immune >=5.00 and <12.0 mIU/ml Indeterminate* >=12.0 mIU/ml Immune *Note for Indeterminate Results: It is recommended that a new specimen be obtained in two weeks and retested.												
		Performing Organization GUTHRIE MEDICAL GROUP LABORATORY	Address 1 GUTHRIE SQUARE	City/State/Zipcode SAYRE, PA 18840 Phone Number 570-887-4719										
	Hepatitis B Surface Antibody	Value: 274.00 mIU/ml Ref Range: See Result Interpretation for Immune Status mIU/ml Text: Hepatitis B Surface 274.00 See Result Interpretation for Immune Status mIU/ml		GUTHRIE MEDICAL GROUP LABORATORY										
01/17/2019	25(OH)D SerPI-mCnc													
	25(OH)D SerPI-mCnc	Value: 31.8 ng/ml Ref Range: 32.0 - 100.0 ng/ml Interpretation: L Text: Vitamin D 25 HYDROXY 31.8 32.0 - 100.0 ng/ml (L)		GUTHRIE MEDICAL GROUP LABORATORY										
	Associated Procedure: 25(OH)D SerPI-mCnc	Text: VITAMIN D 25 HYDROXY (GUTHRIE) (01/17/2019 1:53 PM EST)												
		<table> <tr> <th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr> <tr> <td>Vitamin D 25 HYDROXY</td><td>31.8 (L)</td><td>32.0 - 100.0 ng/ml</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr> </table>	Component	Value	Ref Range	Performed At	Pathologist Signature	Vitamin D 25 HYDROXY	31.8 (L)	32.0 - 100.0 ng/ml	GUTHRIE MEDICAL GROUP LABORATORY			
Component	Value	Ref Range	Performed At	Pathologist Signature										
Vitamin D 25 HYDROXY	31.8 (L)	32.0 - 100.0 ng/ml	GUTHRIE MEDICAL GROUP LABORATORY											
		Specimen Blood specimen (specimen) - Blood - Veni Narrative Interpretation: <20 ng/ml Deficiency 20-<30 ng/ml Insufficiency 32-100 ng/ml Sufficiency >100 ng/ml Potential Toxicity	Performed At GUTHRIE MEDICAL GROUP LABORATORY											
		Performing Organization GUTHRIE MEDICAL GROUP LABORATORY	Address 1 GUTHRIE SQUARE	City/State/Zipcode SAYRE, PA 18840 Phone Number 570-887-4719										
01/17/2019	ESR Bld Qn 15M													
	ESR Bld Qn 15M	Value: 14 MM/HR Ref Range: 0 - 20 MM/HR Text: ESR 14 0 - 20 MM/HR		GUTHRIE MEDICAL GROUP LABORATORY										
	Associated Procedure: ESR Bld Qn 15M	Text: SEDIMENTATION RATE (01/17/2019 1:46 PM EST)												

Date	Test	Component Value	Ref Range	Performed At	Pathologist Signature
		ESR 14	0 - 20 MM/HR	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen			
		Blood specimen (specimen) - Blood - Veni			
		Performing Organization		Address	City/State/Zipcode
		GUTHRIE MEDICAL GROUP LABORATORY		1 GUTHRIE SQUARE	SAYRE, PA 18840
					Phone Number 570-887-4719
01/17/2019	Comp Metab 2000 Pnl SerPI				
	A/G Ratio	Value: 1.1 Ref Range: 0.8 - 2.0 Text: A/G Ratio 1.1 0.8 - 2.0 GUTHRIE MEDICAL GROUP LABORATORY			
	ALP SerPI-cCnc	Value: 62 U/L Ref Range: 40 - 150 U/L Text: Alkaline Phosphatase 62 40 - 150 U/L GUTHRIE MEDICAL GROUP LABORATORY			
	ALT SerPI-cCnc	Value: 28 U/L Ref Range: 9 - 52 U/L Text: ALT 28 9 - 52 U/L GUTHRIE MEDICAL GROUP LABORATORY			
	AST SerPI-cCnc	Value: 34 U/L Ref Range: 15 - 46 U/L Text: AST 34 15 - 46 U/L GUTHRIE MEDICAL GROUP LABORATORY			
	Albumin SerPI-mCnc	Value: 3.9 g/dl Ref Range: 3.5 - 5.0 g/dl Text: Albumin 3.9 3.5 - 5.0 g/dl GUTHRIE MEDICAL GROUP LABORATORY			
	Anion Gap	Value: 8 mmol/L Ref Range: 3 - 11 mmol/L Text: Anion Gap 8 3 - 11 mmol/L GUTHRIE MEDICAL GROUP LABORATORY			
	BUN SerPI-mCnc	Value: 14 mg/dl Ref Range: 7 - 17 mg/dl Text: BUN 14 7 - 17 mg/dl GUTHRIE MEDICAL GROUP LABORATORY			
	BUN/Creatinine Ratio	Value: 14 Ref Range: 6 - 22 Text: BUN/Creatinine Ratio 14 6 - 22 GUTHRIE MEDICAL GROUP LABORATORY			
	Bilirub SerPI-mCnc	Value: 0.1 mg/dl Ref Range: 0.0 - 1.1 mg/dl Text: Total Bilirubin 0.1 0.0 - 1.1 mg/dl GUTHRIE MEDICAL GROUP LABORATORY			
	CO2 SerPI-sCnc	Value: 27 mmol/L Ref Range: 22 - 30 mmol/L Text: CO2 27 22 - 30 mmol/L GUTHRIE MEDICAL GROUP LABORATORY			
	Calcium SerPI-mCnc	Value: 8.9 mg/dl Ref Range: 8.3 - 10.1 mg/dl Text: Calcium 8.9 8.3 - 10.1 mg/dl GUTHRIE MEDICAL GROUP LABORATORY			
	Chloride SerPI-sCnc	Value: 104 mmol/L Ref Range: 98 - 107 mmol/L Text: Chloride 104 98 - 107 mmol/L GUTHRIE MEDICAL GROUP LABORATORY			
	Associated Procedure: Comp Metab 2000 Pnl	Text: COMPREHENSIVE METABOLIC PANEL (01/17/2019 1:45 PM EST)			

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EXHIBIT NO. B2F
PAGE: 222 OF 309

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Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
	SerPI				<div> <div>EXHIBIT NO. B2P</div> <div>PAGE: 223 OF 309</div> </div>	
		Sodium	139	134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
		Potassium	4.2	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
		Chloride	104	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
		CO2	27	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
		Calcium	8.9	8.3 - 10.1 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Albumin	3.9	3.5 - 5.0 g/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		BUN	14	7 - 17 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Creatinine	1.0	0.7 - 1.2 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Glucose	101 (H)	70 - 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Total Protein	7.3	6.3 - 8.2 g/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		Total Bilirubin	0.1	0.0 - 1.1 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
		AST	34	15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
		ALT	28	9 - 52 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
		Alkaline Phosphatase	62	40 - 150 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
		eGFR	>60	See Interpretation Below	GUTHRIE MEDICAL GROUP LABORATORY	
		Comment:		ml/min/1.73ml Sq		

Date	Test				
		<p>Estimated GFR</p> <p>Interpretation:</p> <p>Above 60ml/min/1.73m² = Normal Renal Function</p> <p>30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease</p> <p>15-29 ml/min/1.73m² = Stage 4 Chronic Kidney Disease</p> <p>Less than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease</p> <p>The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:</p> <p>https://www.kidney.org/content/m-dr-d-study-equation</p>			
		BUN/Creatinine Ratio	14	6 - 22	GUTHRIE MEDICAL GROUP LABORATORY
		Anion Gap	8	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
		A/G Ratio	1.1	0.8 - 2.0	GUTHRIE MEDICAL GROUP LABORATORY
		<p>Specimen</p> <p>Blood specimen (specimen) - Blood - Veni</p>			
		Performing Organization	Address	City/State/Zipcode	Phone Number
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
	Creat SerPl-mCnc	<p>Value: 1.0 mg/dl</p> <p>Ref Range: 0.7 - 1.2 mg/dl</p> <p>Text:</p> <p>Creatinine 1.0 0.7 - 1.2 mg/dl GUTHRIE MEDICAL GROUP LABORATORY</p>			
	GFR/BSA.pred SerPl MDRD-ArVRat	<p>Value: >60</p> <p>Ref Range: See Interpretation Below ml/min/1.73ml Sq</p> <p>Text:</p>			

Date	Test																			
		<div><div>Comment:</div><div>Estimated GFR Interpretation: Above 60ml/min/1.73m2 = Normal Renal Function 30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/m-dr-d-study-equation</div></div>																		
	Glucose SerPI-mCnc	<div><div>Value: 101 mg/dl Ref Range: 70 - 99 mg/dl Interpretation: H Text: Glucose 101 70 - 99 mg/dl (H) GUTHRIE MEDICAL GROUP LABORATORY</div></div>																		
	Potassium SerPI-sCnc	<div><div>Value: 4.2 mmol/L Ref Range: 3.5 - 5.1 mmol/L Text: Potassium 4.2 3.5 - 5.1 mmol/L GUTHRIE MEDICAL GROUP LABORATORY</div></div>																		
	Prot SerPI-mCnc	<div><div>Value: 7.3 g/dl Ref Range: 6.3 - 8.2 g/dl Text: Total Protein 7.3 6.3 - 8.2 g/dl GUTHRIE MEDICAL GROUP LABORATORY</div></div>																		
	Sodium SerPI-sCnc	<div><div>Value: 139 mmol/L Ref Range: 134 - 145 mmol/L Text: Sodium 139 134 - 145 mmol/L GUTHRIE MEDICAL GROUP LABORATORY</div></div>																		
01/17/2019	CRP SerPI-mCnc																			
	CRP SerPI-mCnc	<div><div>Value: 1.10 mg/dl Ref Range: <1.00 mg/dl Interpretation: H Text: C-Reactive Protein 1.10 <1.00 mg/dl (H) GUTHRIE MEDICAL GROUP LABORATORY</div></div>																		
	Associated Procedure: CRP SerPI-mCnc	<div><div>Text: C-REACTIVE PROTEIN (01/17/2019 1:45 PM EST) <table><tr><th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr><tr><td>C-Reactive Protein</td><td>1.10 (H)</td><td><1.00 mg/dl</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr></table>Specimen Blood specimen (specimen) - Blood - Veni <table><tr><th>Performing Organization</th><th>Address</th><th>City/State/Zipcode</th><th>Phone Number</th></tr><tr><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td>1 GUTHRIE SQUARE</td><td>SAYRE, PA 18840</td><td>570-887-4719</td></tr></table></div></div>	Component	Value	Ref Range	Performed At	Pathologist Signature	C-Reactive Protein	1.10 (H)	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY		Performing Organization	Address	City/State/Zipcode	Phone Number	GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
Component	Value	Ref Range	Performed At	Pathologist Signature																
C-Reactive Protein	1.10 (H)	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY																	
Performing Organization	Address	City/State/Zipcode	Phone Number																	
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719																	
01/17/2019	85025																			
	Associated Procedure: #Result150855800	<div><div>Text: CBC WITH DIFFERENTIAL (01/17/2019 1:17 PM EST)</div></div>																		

Date	Test	Procedure	Component	Value	Ref Range	Performed At	Pathologist Signature
<div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 554 of 1112</div> <div>EXHIBIT NO. B2P</div> <div>PAGE: 226 OF 309</div>							
			WBC Count	9.95	3.98 - 10.04	GUTHRIE MEDICAL GROUP	
			Comment:	Methodology was changed 1/3/2019. Please note updated reference range and units.			
			RBC Count	4.46	3.93 - 5.22	GUTHRIE MEDICAL GROUP	
			Hemoglobin	13.4	M/UL 11.2 - 15.7	LABORATORY GUTHRIE MEDICAL GROUP	
			Hematocrit	41.6	G/DL 34.1 - 44.9 %	LABORATORY GUTHRIE MEDICAL GROUP	
			MCV	93.3	LABORATORY 79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP	
			MCH	30.0	LABORATORY 25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP	
			MCHC	32.2	LABORATORY 32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP	
			Platelet Count	310	LABORATORY 182 - 369 K/uL	GUTHRIE MEDICAL GROUP	
			MPV	9.8	LABORATORY 9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP	
			RDW	12.4	LABORATORY 11.7 - 14.4 %	GUTHRIE MEDICAL GROUP	
			Neutrophil %	62.2	LABORATORY 34.0 - 71.1 %	GUTHRIE MEDICAL GROUP	
			Lymphocyte %	26.6	LABORATORY 19.3 - 51.7 %	GUTHRIE MEDICAL GROUP	
			Monocyte %	8.2	LABORATORY 4.7 - 12.5 %	GUTHRIE MEDICAL GROUP	
			Eosinophil %	2.0	LABORATORY 0.7 - 5.8 %	GUTHRIE MEDICAL GROUP	
			Basophil %	0.7	LABORATORY 0.1 - 1.2 %	GUTHRIE MEDICAL GROUP	
			nRBC %	0.0	LABORATORY 0.0 - 0.2 %	GUTHRIE MEDICAL GROUP	
			Neutrophil #	6.18 (H)	LABORATORY 1.56 - 6.13 K/UL	GUTHRIE MEDICAL GROUP	
			Lymphocyte #	2.65	LABORATORY 1.18 - 3.74 K/UL	GUTHRIE MEDICAL GROUP	
			Monocyte #	0.82	LABORATORY 0.24 - 0.86 K/UL	GUTHRIE MEDICAL GROUP	

Date	Test	Value	Ref Range	Text
	Eosinophil #	0.20	0.04 - 0.36 K/UL	GUTHRIE MEDICAL GROUP LABORATORY
	Basophil #	0.07	0.01 - 0.08 K/UL	GUTHRIE MEDICAL GROUP LABORATORY
	Immature Gran %	0.3	0.0 - 0.4 %	GUTHRIE MEDICAL GROUP LABORATORY
	Immature Gran #	0.03	0.00 - 0.03 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	NRBC #	0.00	0.00 - 0.12 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Specimen			
	Blood specimen (specimen) - Blood - Veni			
	Performing Organization	Address	City/State/Zipcode	Phone Number
	GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
Basophils # Bld Auto	Value: 0.07 K/UL Ref Range: 0.01 - 0.08 K/UL Text: Basophil # 0.07 0.01 - 0.08 K/UL GUTHRIE MEDICAL GROUP LABORATORY			
Basophils NFr Bld Auto	Value: 0.7 % Ref Range: 0.1 - 1.2 % Text: Basophil % 0.7 0.1 - 1.2 % GUTHRIE MEDICAL GROUP LABORATORY			
Eosinophil # Bld Auto	Value: 0.20 K/UL Ref Range: 0.04 - 0.36 K/UL Text: Eosinophil # 0.20 0.04 - 0.36 K/UL GUTHRIE MEDICAL GROUP LABORATORY			
Eosinophil NFr Bld Auto	Value: 2.0 % Ref Range: 0.7 - 5.8 % Text: Eosinophil % 2.0 0.7 - 5.8 % GUTHRIE MEDICAL GROUP LABORATORY			
Hct VFr Bld Auto	Value: 41.6 % Ref Range: 34.1 - 44.9 % Text: Hematocrit 41.6 34.1 - 44.9 % GUTHRIE MEDICAL GROUP LABORATORY			
Hgb Bld-mCnc	Value: 13.4 G/DL Ref Range: 11.2 - 15.7 G/DL Text: Hemoglobin 13.4 11.2 - 15.7 G/DL GUTHRIE MEDICAL GROUP LABORATORY			
Imm Granulocytes # Bld Auto	Value: 0.03 K/uL Ref Range: 0.00 - 0.03 K/uL Text: Immature Gran # 0.03 0.00 - 0.03 K/uL GUTHRIE MEDICAL GROUP LABORATORY			
Imm Granulocytes NFr Bld Auto	Value: 0.3 % Ref Range: 0.0 - 0.4 % Text: Immature Gran % 0.3 0.0 - 0.4 % GUTHRIE MEDICAL GROUP LABORATORY			
Lymphocytes # Bld Auto	Value: 2.65 K/UL Ref Range: 1.18 - 3.74 K/UL Text: Lymphocyte # 2.65 1.18 - 3.74 K/UL GUTHRIE MEDICAL GROUP LABORATORY			
Lymphocytes NFr Bld Auto	Value: 26.6 % Ref Range: 19.3 - 51.7 % Text: Lymphocyte % 26.6 19.3 - 51.7 % GUTHRIE MEDICAL GROUP LABORATORY			

Date	Test	Value	Ref Range	Text
	MCH RBC Qn Auto	30.0 PG	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY
	MCHC RBC Auto-mCnc	32.2 g/dL	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
	MCV RBC Auto	93.3 FL	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	0.82 K/UL	0.24 - 0.86 K/UL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes NFr Bld Auto	8.2 %	4.7 - 12.5 %	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils # Bld Auto	6.18 K/UL	1.56 - 6.13 K/UL	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils NFr Bld Auto	62.2 %	34.0 - 71.1 %	GUTHRIE MEDICAL GROUP LABORATORY
	PMV Bld Auto	9.8 FL	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY
	Platelet # Bld Auto	310 K/uL	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	RBC # Bld Auto	4.46 M/UL	3.93 - 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY
	RDW RBC Auto-Rto	12.4 %	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY
	WBC # Bld Auto	9.95 K/uL	3.98 - 10.04 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	nRBC # Bld Auto	0.00 K/uL	0.00 - 0.12 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	nRBC/100 WBC Bld Auto-Rto	0.0 %	0.0 - 0.2 %	GUTHRIE MEDICAL GROUP LABORATORY

Date	Test	
12/23/2018	1098	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 557 of 1112
	Associated Procedure: #Result150855778 Procedure	EXHIBIT NO. B2F PAGE: 229 OF 309
	Unknown	<p>Text: MR PELVIS W AND WO CONTRAST (12/23/2018 2:44 PM EST)</p> <p>Specimen Impressions Performed At</p> <p>IMPRESSION:</p> <p>Follicles are seen involving both ovaries, within normal limits for a patient of reproductive age. Of note there is a 23 mm right ovarian corpus luteal cyst. There is no definitive MR evidence for a endometrioma involving the left ovary, as previously suggested on ultrasound.</p> <p>RECOMMENDATION:</p> <p>No specific imaging recommendation.</p> <p>Thank you for this kind referral,</p> <p>SAREL GAUR MD Diagnostic and Interventional Radiologist c 570.423.2146</p> <p>Signed by Sarel Gaur on 12/23/2018 2:44 PM</p> <p>Narrative Performed At</p> <p>This result has an attachment that is not available.</p> <p>PROCEDURE(S): MR PELVIS W AND WO CONTRAST (Contrast Enhanced MR of the Pelvis)</p> <p>DATE OF SERVICE: 12/13/2018 6:38 PM</p> <p>PROVIDED CLINICAL INFORMATION: 42 years, Female, "Adnexal mass, US complex or solid mass, follow up: rule out endometrioma"</p> <p>PROCEDURE AND MATERIALS: Standard protocol. (multiplanar multisequence MR imaging of the pelvis was obtained)</p> <p>CONTRAST: IV contrast only.</p> <p>COMPARISON STUDIES: Ultrasound dated November 8, 2018 and report from August 13, 2018</p> <p>OBSERVATIONS:</p>

Date	Test
	<div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 558 of 1112</div> <div>EXHIBIT NO. B2F PAGE: 230 OF 309</div> <p>VESSELS: Normal caliber aorta.</p> <p>REPRODUCTIVE ORGANS: Several cysts are seen involving both ovaries, more prominent involving the right ovary. There is a 23 mm right ovarian peripherally hyperenhancing cyst most compatible with a corpus luteal cyst.</p> <p>PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.</p> <p>BLADDER: Unremarkable.</p> <p>BONES: No aggressive lesions.</p> <p>ABDOMINAL WALL: Unremarkable.</p> <p style="text-align: right;">Procedure Note</p> <p>Interface, Rad Results - 12/23/2018 2:46 PM EST</p> <p>PROCEDURE(S): MR PELVIS W AND WO CONTRAST (Contrast Enhanced MR of the Pelvis)</p> <p>DATE OF SERVICE: 12/13/2018 6:38 PM</p> <p>PROVIDED CLINICAL INFORMATION: 42 years, Female, "Adnexal mass, US complex or solid mass, follow up: rule out endometrioma"</p> <p>PROCEDURE AND MATERIALS: Standard protocol. (multiplanar multisequence MR imaging of the pelvis was obtained)</p> <p>CONTRAST: IV contrast only.</p> <p>COMPARISON STUDIES: Ultrasound dated November 8, 2018 and report from August 13, 2018</p> <p>OBSERVATIONS:</p> <p>VESSELS: Normal caliber aorta.</p> <p>REPRODUCTIVE ORGANS: Several cysts are seen involving both ovaries, more prominent involving the right ovary. There is a 23 mm right ovarian peripherally hyperenhancing cyst most compatible with a corpus</p>

Date	Test																			
		<p>luteal cyst.</p> <p>PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.</p> <p>BLADDER: Unremarkable.</p> <p>BONES: No aggressive lesions.</p> <p>ABDOMINAL WALL: Unremarkable.</p> <p>IMPRESSION</p> <p>IMPRESSION:</p> <p>Follicles are seen involving both ovaries, within normal limits for a patient of reproductive age. Of note there is a 23 mm right ovarian corpus luteal cyst. There is no definitive MR evidence for a endometrioma involving the left ovary, as previously suggested on ultrasound.</p> <p>RECOMMENDATION:</p> <p>No specific imaging recommendation.</p> <p>Thank you for this kind referral,</p> <p>SAREL GAUR MD Diagnostic and Interventional Radiologist</p> <p>c 570.423.2146</p> <p>Signed by Sarel Gaur on 12/23/2018 2:44 PM</p>																		
12/22/2018	Bacteria Ur Cult																			
	Bacteria Ur Cult	<p>Value: No growth of clinical significance</p> <p>Text: Urine Culture No growth of clinical significance GUTHRIE MEDICAL GROUP LABORATORY</p>																		
	Associated Procedure: Bacteria Ur Cult	<p>Text: URINE CULTURE (C&S) (12/22/2018 1:58 PM EST)</p> <table><tr><th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr><tr><td>Urine Culture</td><td>No growth of clinical significance</td><td></td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr></table> <p>Specimen Urine specimen (specimen) - URINE CLEAN CATCH</p> <table><tr><th>Performing Organization</th><th>Address</th><th>City/State/Zipcode</th><th>Phone Number</th></tr><tr><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td>1 GUTHRIE SQUARE</td><td>SAYRE, PA 18840</td><td>570-887-4719</td></tr></table>	Component	Value	Ref Range	Performed At	Pathologist Signature	Urine Culture	No growth of clinical significance		GUTHRIE MEDICAL GROUP LABORATORY		Performing Organization	Address	City/State/Zipcode	Phone Number	GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
Component	Value	Ref Range	Performed At	Pathologist Signature																
Urine Culture	No growth of clinical significance		GUTHRIE MEDICAL GROUP LABORATORY																	
Performing Organization	Address	City/State/Zipcode	Phone Number																	
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719																	
12/21/2018	81002																			
	Associated Procedure: #Result150855781	<p>Text: URINE DIP MANUAL (AMB POCT) (12/21/2018)</p>																		

Date	Test	Component	Value	Ref Range	Performed	Pathologist Signature
<div> <div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 560 of 1112</div> <div>EXHIBIT NO. B2F</div> <div>PAGE: 232 OF 309</div> </div>						
	Procedure	URINE GLUCOSE (POCT)	Negative	Negative mg/dl	GUTHRIE CLINIC POCT	
		URINE BILIRUBIN (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
		Urine Ketones (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
		URINE SPECIFIC GRAVITY (POCT)	1.015	1.005 - 1.030	GUTHRIE CLINIC POCT	
		URINE BLOOD (POCT)	Trace-Intact (A)	Negative	GUTHRIE CLINIC POCT	
		URINE PH (POCT)	6.0	5.0 - 8.0	GUTHRIE CLINIC POCT	
		URINE PROTEIN (POCT)	Negative	Negative mg/dl	GUTHRIE CLINIC POCT	
		URINE UROBILINOGEN (POCT)	0.2	0.2 - 1.0 mg/dl	GUTHRIE CLINIC POCT	
		URINE NITRITES (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
		URINE LEUKOCYTES (POCT)	Small (A)	Negative	GUTHRIE CLINIC POCT	
		Specimen				
		Performing Organization	Address	City/State/Zip	Phone Number	
		GUTHRIE CLINIC POCT	1 Guthrie Square	Sayre, PA 18840		
	URINE BILIRUBIN (POCT)	Value: Negative Ref Range: Negative Text: URINE BILIRUBIN (POCT) Negative Negative GUTHRIE CLINIC POCT				
	URINE BLOOD (POCT)	Value: Trace-Intact Ref Range: Negative Interpretation: A Text: URINE BLOOD (POCT) Trace-Intact (A) Negative GUTHRIE CLINIC POCT				
	URINE GLUCOSE (POCT)	Value: Negative Ref Range: Negative mg/dl Text: URINE GLUCOSE (POCT) Negative Negative mg/dl GUTHRIE CLINIC POCT				
	URINE LEUKOCYTES (POCT)	Value: Small Ref Range: Negative Interpretation: A Text: URINE LEUKOCYTES (POCT) Small Negative GUTHRIE CLINIC POCT (A)				
	URINE NITRITES (POCT)	Value: Negative Ref Range: Negative Text: URINE NITRITES (POCT) Negative Negative GUTHRIE CLINIC POCT				
	URINE PH (POCT)	Value: 6.0 Ref Range: 5.0 - 8.0 Text: URINE PH (POCT) 6.0 5.0 - 8.0 GUTHRIE CLINIC POCT				
	URINE PROTEIN (POCT)	Value: Negative Ref Range: Negative mg/dl Text: URINE PROTEIN (POCT) Negative Negative mg/dl GUTHRIE CLINIC POCT				
	URINE SPECIFIC GRAVITY (POCT)	Value: 1.015 Ref Range: 1.005 - 1.030 Text: URINE SPECIFIC GRAVITY (POCT) 1.015 1.005 - 1.030 GUTHRIE CLINIC POCT				

Date	Test	Value	Ref Range	Text	EXHIBIT NO. B2F	PAGE: 233 OF 309
	URINE UROBILINOGEN (POCT)	0.2 mg/dl	0.2 - 1.0 mg/dl	URINE UROBILINOGEN (POCT) 0.2 0.2 - 1.0 mg/dl	GUTHRIE CLINIC POCT	
	Urine Ketones (POCT)	Negative	Negative	Urine Ketones (POCT) Negative Negative	GUTHRIE CLINIC POCT	

11/14/2018	26057
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Associated Procedure: #Result149957031 Procedure	
Unknown	<p>Text: US PELVIC COMPLETE WITH EV PROBE (11/14/2018 3:45 AM EST)</p> <p>Specimen Impressions Performed At</p> <p>IMPRESSION:</p> <p>There is a minimally complex right ovarian cystic lesion favoring an evolving hemorrhagic cyst.</p> <p>Size stable echogenic lesion of the left ovary. An MRI of the pelvis with and without intravenous contrast could be acquired to exclude an endometrioma if warranted.</p> <p>Additionally, there is apparent cystic change within the nonthickened endometrium. Possibly representing a focus of evolving cystic endometrial hyperplasia. Tissue sampling could be acquired for further characterization and to exclude other less common etiologies.</p> <p>Otherwise, attention at routine imaging follow-up is requested.</p> <p>Signed by Patrick Dyer, MD on 11/14/2018 3:45 AM</p> <p>Narrative Performed At</p> <p>Procedure(s): US PELVIC COMPLETE WITH EV PROBE</p> <p>Date of service: 11/8/2018 11:05 AM</p> <p>History: 42 years, Female, "Follow up endometrioma left ovary"</p> <p>Technique: A transabdominal and transvaginal sonogram of the pelvis was performed using color and grayscale technique.</p> <p>Findings:</p> <p>Uterus:The uterus demonstrates normal parenchymal echotexture and echogenicity. The endometrial myometrial junction is well-maintained.</p> <p>The uterus measures 7.2 x 2.9 x 3.8 cm.</p> <p>Endometrium: There are tiny anechoic cysts within the endometrium. The endometrium is not thickened (Time stamp 11: 21: 18, A.M.). Small minimally complicated nabothian cysts are seen along the cervix. The lower uterine segment is otherwise within normal limits. The</p>

Date	Test
	<p>Endometrium measures 8 mm when measured accurately.</p> <p>Ovaries: There is a 2.0 cm circumscribed right ovarian cyst containing thickened internal septations and a nodular echogenic component along its anterolateral border, new since prior examination. There is a 1.8 x 1.7 cm x 2.0 circumscribed, homogeneously echogenic left renal lesion, previously measuring 2.1 cm. (Time stamp 11: 27: 11, A.M.). Spectral interrogation of the ovaries was not performed.</p> <p>The right ovary measures 4.6 x 2.1 x 2.8 cm.</p> <p>The left ovary measures 3.6 x 2.8 x 2.0 cm.</p> <p>Adnexa: There are no adnexal masses or significant free fluid.</p> <p style="text-align: center;">Procedure Note</p> <p>Interface, Rad Results - 11/14/2018 3:47 AM EST</p> <p>Procedure(s): US PELVIC COMPLETE WITH EV PROBE</p> <p>Date of service: 11/8/2018 11:05 AM</p> <p>History: 42 years, Female, "Follow up endometrioma left ovary"</p> <p>Technique: A transabdominal and transvaginal sonogram of the pelvis was performed using color and grayscale technique.</p> <p>Findings:</p> <p>Uterus: The uterus demonstrates normal parenchymal echotexture and echogenicity. The endometrial myometrial junction is well-maintained.</p> <p>The uterus measures 7.2 x 2.9 x 3.8 cm.</p> <p>Endometrium: There are tiny anechoic cysts within the endometrium. The endometrium is not thickened (Time stamp 11: 21: 18, A.M.). Small minimally complicated nabothian cysts are seen along the cervix. The lower uterine segment is otherwise within normal limits. The endometrium measures 8 mm when measured accurately.</p> <p>Ovaries: There is a 2.0 cm circumscribed right ovarian cyst containing thickened internal septations and a nodular echogenic component along its anterolateral border, new since prior examination. There is a 1.8</p>

Date	Test	
		<p>x 1.7 cm x 2.0 circumscribed, homogeneously echogenic left renal lesion, previously measuring 2.1 cm. (Time stamp 11: 27: 11, A.M.).</p> <p>Spectral interrogation of the ovaries was not performed.</p> <p>The right ovary measures 4.6 x 2.1 x 2.8 cm.</p> <p>The left ovary measures 3.6 x 2.8 x 2.0 cm.</p> <p>Adnexa: There are no adnexal masses or significant free fluid.</p> <p>IMPRESSION</p> <p>IMPRESSION:</p> <p>There is a minimally complex right ovarian cystic lesion favoring an evolving hemorrhagic cyst.</p> <p>Size stable echogenic lesion of the left ovary. An MRI of the pelvis with and without intravenous contrast could be acquired to exclude an endometrioma if warranted.</p> <p>Additionally, there is apparent cystic change within the nonthickened endometrium. Possibly representing a focus of evolving cystic endometrial hyperplasia. Tissue sampling could be acquired for further characterization and to exclude other less common etiologies.</p> <p>Otherwise, attention at routine imaging follow-up is requested.</p> <p>Signed by Patrick Dyer, MD on 11/14/2018 3:45 AM</p>
11/12/2018	Comp Metab 2000 Pnl SerPI	
	A/G Ratio	<p>Value: 1.2</p> <p>Ref Range: 0.8 - 2.0</p> <p>Text:</p> <p>A/G Ratio 1.2 0.8 - 2.0 GUTHRIE MEDICAL GROUP LABORATORY</p>
	ALP SerPI-cCnc	<p>Value: 49 U/L</p> <p>Ref Range: 40 - 150 U/L</p> <p>Text:</p> <p>Alkaline Phosphatase 49 40 - 150 U/L GUTHRIE MEDICAL GROUP LABORATORY</p>
	ALT SerPI-cCnc	<p>Value: 36 U/L</p> <p>Ref Range: 9 - 52 U/L</p> <p>Text:</p> <p>ALT 36 9 - 52 U/L GUTHRIE MEDICAL GROUP LABORATORY</p>

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Date	Test	Value	Ref Range	Text	Pathologist Signature
	AST SerPI-mCnc	37 U/L	15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	EXHIBIT NO. B2F PAGE: 236 OF 309
	Albumin SerPI-mCnc	4.0 g/dL	3.5 - 5.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	Anion Gap	9 mmol/L	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
	BUN SerPI-mCnc	14 mg/dL	7 - 17 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	BUN/Creatinine Ratio	20	6 - 22	GUTHRIE MEDICAL GROUP LABORATORY	
	Bilirub SerPI-mCnc	0.3 mg/dL	0.0 - 1.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	CO2 SerPI-sCnc	29 mmol/L	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
	Calcium SerPI-mCnc	8.9 mg/dL	8.3 - 10.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	Chloride SerPI-sCnc	103 mmol/L	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
	Associated Procedure: Comp Metab 2000 Pnl SerPI	Text: COMPREHENSIVE METABOLIC PANEL (11/12/2018 1:04 PM EST)			
		Component	Value	Ref Range	Performed At
		Sodium	141	134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
		Potassium	4.0	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
		Chloride	103	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
		CO2	29	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
		Calcium	8.9	8.3 - 10.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY

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Date	Test	Result	Reference Range	LABORATORY
	Albumin	4.0	3.8 - 5.0 g/dL	GUTHRIE MEDICAL GROUP
	BUN	14	7 - 17 mg/dL	GUTHRIE MEDICAL GROUP
	Creatinine	0.7	0.7 - 1.2 mg/dL	GUTHRIE MEDICAL GROUP
	Glucose	105 (H)	70 - 99 mg/dL	GUTHRIE MEDICAL GROUP
	Total Protein	7.3	6.3 - 8.2 g/dL	GUTHRIE MEDICAL GROUP
	Total Bilirubin	0.3	0.0 - 1.1 mg/dL	GUTHRIE MEDICAL GROUP
	AST	37	15 - 46 U/L	GUTHRIE MEDICAL GROUP
	ALT	36	9 - 52 U/L	GUTHRIE MEDICAL GROUP
	Alkaline Phosphatase	49	40 - 150 U/L	GUTHRIE MEDICAL GROUP
	eGFR	>60	See Interpretation Below	GUTHRIE MEDICAL GROUP
		Comment:	ml/min/1.73m ² Sq	LABORATORY
		<p>Estimated GFR Interpretation:</p> <p>Above 60ml/min/1.73m² = Normal Renal Function</p> <p>30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease</p> <p>15-29 ml/min/1.73m² = Stage 4 Chronic Kidney Disease</p> <p>Less than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease</p> <p>The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:</p>		
		<p>https://www.kidney.org/content/mrd-study-</p>		

Test					EXHIBIT NO. B2F PAGE: 238 OF 309	
BUN/Creatinine Ratio	20	6 - 22	GUTHRIE MEDICAL GROUP LABORATORY			
Anion Gap	9	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY			
A/G Ratio	1.2	0.8 - 2.0	GUTHRIE MEDICAL GROUP LABORATORY			
Specimen						
Blood specimen (specimen) - Blood - Veni						
Performing Organization		Address	City/State/Zipcode	Phone Number		
GUTHRIE MEDICAL GROUP LABORATORY		1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719		
Creat SerPl-mCnc	Value: 0.7 mg/dL Ref Range: 0.7 - 1.2 mg/dL Text: Creatinine 0.7 0.7 - 1.2 mg/dL GUTHRIE MEDICAL GROUP LABORATORY					
GFR/BSA.pred SerPl MDRD-ArVRat	Value: >60 Ref Range: See Interpretation Below ml/min/1.73m ² Sq Text: eGFR>60 See Interpretation Below ml/min/1.73m ² Sq GUTHRIE MEDICAL GROUP LABORATORY Comment: Estimated GFR Interpretation: Above 60ml/min/1.73m ² = Normal Renal Function 30-59 ml/min/1.73m ² = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m ² = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m ² = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/mrd-study-equation					
Glucose SerPl-mCnc	Value: 105 mg/dL Ref Range: 70 - 99 mg/dL Interpretation: H Text: Glucose 105 70 - 99 mg/dL GUTHRIE MEDICAL GROUP LABORATORY (H)					
Potassium SerPl-sCnc	Value: 4.0 mmol/L Ref Range: 3.5 - 5.1 mmol/L Text: Potassium 4.0 3.5 - 5.1 mmol/L GUTHRIE MEDICAL GROUP LABORATORY					
Prot SerPl-mCnc	Value: 7.3 g/dL Ref Range: 6.3 - 8.2 g/dL Text: Total Protein 7.3 6.3 - 8.2 g/dL GUTHRIE MEDICAL GROUP LABORATORY					

Date	Test	Value:	Ref Range:	Text:	EXHIBIT NO. B2F	PAGE: 239 OF 309
	Sodium Serp T-5010	141 mmol/L	134 - 145 mmol/L	Sodium 141 134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
11/12/2018	85025					
	Associated Procedure: #Result150855770 Procedure	Text: CBC WITH DIFFERENTIAL (11/12/2018 12:37 PM EST)				Pathologist Signature
		Component	Value	Ref Range	Performed At	
		WBC Count	11.6 (H)	3.6 - 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		RBC Count	4.69	3.80 - 5.20 M/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hemoglobin	14.2	12.0 - 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hematocrit	43.2	35.0 - 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		MCV	92.1	80.0 - 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY	
		MCH	30.2	26.0 - 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY	
		MCHC	32.8	32.0 - 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Platelet Count	343	150 - 400 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		MPV	7.6	7.1 - 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY	
		RDW	13.0	11.0 - 15.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil %	59.4	38.0 - 70.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte %	28.6	21.0 - 49.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte %	8.8	1 - 11 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Eosinophil %	2.3	0.0 - 7.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil %	0.9	0.0 - 2.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil #	6.9	1.8 - 7.7 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte #	3.3	1.0 - 5.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte #	1.0 (H)	0.0 - 0.8 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Eosinophil #	0.3	0.0 - 0.5 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil #	0.1	0.0 - 0.2 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen Blood specimen (specimen) - Blood - Veni				
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719	
	Basophils # Bld Auto	Value: 0.1 K/uL Ref Range: 0.0 - 0.2 K/uL Text: Basophil # 0.1 0.0 - 0.2 K/uL				
		GUTHRIE MEDICAL GROUP LABORATORY				

Date	Test	Value	Ref Range	Text
	Basophils NFr Bld Auto	0.9 %	0.0 - 2.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	Eosinophil # Bld Auto	0.3 K/uL	0.0 - 0.5 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Eosinophil NFr Bld Auto	2.3 %	0.0 - 7.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	Hct VFr Bld Auto	43.2 %	35.0 - 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	Hgb Bld-mCnc	14.2 g/dL	12.0 - 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes # Bld Auto	3.3 K/uL	1.0 - 5.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes NFr Bld Auto	28.6 %	21.0 - 49.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	MCHC RBC Auto-mCnc	30.2 pg	26.0 - 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY
	MCV RBC Auto	32.8 g/dL	32.0 - 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	1.0 K/uL	0.0 - 0.8 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	92.1 fL	80.0 - 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes NFr Bld Auto	8.8 %	1 - 11 %	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils # Bld Auto	6.9 K/uL	1.8 - 7.7 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils # Bld Auto	7.6 fL	7.1 - 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY

Date	Test	
	Neutrophils NF F Bld Auto	<div> <div>Value: 59.4 %</div> <div>Ref Range: 38.0 - 70.0 %</div> <div>Text:</div> <div>Neutrophil % 59.4 38.0 - 70.0 % GUTHRIE MEDICAL GROUP LABORATORY</div> </div>
	PBG 24h Ur-mRate	<div> <div>Value: 11.6 K/uL</div> <div>Ref Range: 3.6 - 11.0 K/uL</div> <div>Interpretation: H</div> <div>Text:</div> <div>WBC Count 11.6 3.6 - 11.0 K/uL (H) GUTHRIE MEDICAL GROUP LABORATORY</div> </div>
	Prot C PPP Chro-aCnc	<div> <div>Value: 343 K/uL</div> <div>Ref Range: 150 - 400 K/uL</div> <div>Text:</div> <div>Platelet Count 343 150 - 400 K/uL GUTHRIE MEDICAL GROUP LABORATORY</div> </div>
	RDW RBC Auto-Rto	<div> <div>Value: 4.69 M/uL</div> <div>Ref Range: 3.80 - 5.20 M/uL</div> <div>Text:</div> <div>RBC Count 4.69 3.80 - 5.20 M/uL GUTHRIE MEDICAL GROUP LABORATORY</div> </div>
	WBC nRBC cor # Bld Auto	<div> <div>Value: 13.0 %</div> <div>Ref Range: 11.0 - 15.0 %</div> <div>Text:</div> <div>RDW 13.0 11.0 - 15.0 % GUTHRIE MEDICAL GROUP LABORATORY</div> </div>
11/09/2018	3188	
	Associated Procedure: #Result149957024 Procedure	
	Unknown	<div> <div>Text:</div> <div>EMG/NCV (11/09/2018)</div> <div> <div>Specimen</div> <div>Narrative</div> <div>Performed At</div> </div> <div>This result has an attachment that is not available.</div> <div>Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie.</div> </div>
10/13/2018	89325	
	Associated Procedure: #Result148540288 Procedure	<div> <div>Text:</div> <div>ANTI HISTONE ANTIBODY (10/13/2018 12:26 AM EDT)</div> <div> <div>Component</div> <div>Value</div> <div>Ref Range</div> <div>Performed At</div> <div>Pathologist Signature</div> </div> <div> <div>Antihistone Antibody</div> <div>1.7 (H)</div> <div><1.0 U</div> <div>QUEST DIAGNOSTICS</div> </div> <div>Comment:</div> <div>REFERENCE RANGE:</div> <div><1.0</div> <div>Negative</div> <div>1.0 to 1.5 Weak</div> <div>Positive</div> <div>1.6 to 2.5 Moder</div> <div>ate Positive</div> <div>>2 .5 Strong</div> <div>Positive</div> <div>Specimen</div> <div>Blood specimen (specimen) - Blood - Veni</div> </div>
		565

Date	Test
	<div> <div> <div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 570 of 1112</div> <div>EXHIBIT NO: B21</div> <div>QUEST DIAGNOSTICS</div> <div>PAGE: 242 OF 309</div> </div> <div> <div>Narrative</div> <div> <div>Performing Organization Information:</div> <div>Site ID: G</div> <div>Name: QUEST DIAGNOSTICS NICHOLS INSTITUTE</div> <div>Address: 14225 NEWBROOK DRIVE CHANTILLY, VA 20151</div> <div>Director: PATRICK W MASON, MD, PHD</div> <div> <div>Performing Organization</div> <div>Address</div> <div>City/State/Zipcode</div> <div>Phone Number</div> </div> <div> <div>QUEST DIAGNOSTICS</div> <div>875 GREENTREE RD, 4 PARKWAY CENTER</div> <div>PITTSBURGH, PA 15220</div> <div>607-936-0146</div> </div> </div> </div> <div> <div>Histone Ab Ser EIA-aCnc</div> <div> <div>Value: 1.7 U</div> <div>Ref Range: <1.0 U</div> <div>Interpretation: H</div> <div>Text:</div> <div> <div>Antihistone Antibody 1.7 (H)</div> <div><1.0 U QUEST DIAGNOSTICS</div> </div> <div>Comment:</div> <div> <div>REFERENCE RANGE:</div> <div> <div><1.0</div> <div>1.0 to 1.5</div> <div>1.6 to 2.5</div> <div>>2.5</div> </div> <div> <div>Negative</div> <div>Weak Positive</div> <div>Moder ate Positive</div> <div>Strong Positive</div> </div> </div> </div> </div> </div>
10/13/2018	<div> <div>ENA Ab Pnl Ser</div> <div>ANA Ser QI IF</div> </div>
	<div> <div>Value: POSITIVE</div> <div>Ref Range: NEGATIVE</div> <div>Interpretation: A</div> <div>Text:</div> <div> <div>ANA Screen</div> <div>POSITIVE (A)</div> <div>NEGATIVE QUEST DIAGNOSTICS</div> </div> <div>Comment:</div> <div> <div>ANA IFA is a first line screen for detecting the presence of up to approximately 150 autoantibodies in varius autoimmune diseases. A positive ANA IFA result is suggestive of autoimmune disease and reflexes to titer and pattern. Further laboratory testing may be considered if clinically indicated.</div> <div> <div>TITER</div> <div>INTERPRETATION</div> <div>-----</div> <div> <div><1:40</div> <div>1:40 - 1:80</div> <div>>1:80</div> </div> <div> <div>NEGATIVE</div> <div>LOW ANTIBODY LEVEL</div> <div>ELEVATED ANTIBODY LEVEL</div> </div> </div> <div> <div>Visit Physician FAQs for interpretation of all antibodies in the Cascade, prevalence, and association with diseases at http://education .QuestDiagnostic</div> </div> </div> </div>

Associated Procedure:
ENA Ab Pnl Ser

Text:
ANTI NUCLEAR ANTIBODY (10/13/2018 12:26 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
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ANA Screen POSITIVE (A)	NEGATIVE QUEST DIAGNOSTICS
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Comment:

ANA IFA is a first line screen for detecting the presence of up to approximately 150 autoantibodies in various autoimmune diseases. A positive ANA IFA result is suggestive of autoimmune disease and reflexes to titer and pattern. Further laboratory testing may be considered if clinically indicated.

TITER INTERPRETATION

<1:40	NEGATIVE
1:40 - 1:80	LOW ANTIBODY
LEVEL	
>1:80	ELEVATED
ANTIBODY LEVEL	

Visit Physician FAQs for interpretation of all antibodies in the Cascade, prevalence, and association with diseases at <http://education.questdiagnostics.com/faq/FAQ177>

Specimen

Blood specimen (specimen) - Blood - Veni

Narrative

Performing Organization Information:

Site ID: P

Name: QUEST DIAGNOSTICS

Address: 875 GREENTREE ROAD, 4 PARKWAY CENTER
PITTSBURGH, PA 15220

Director: KAMBIZ MERATI, MD

Performing Organization

Address

City/State/Zipcode

Phone Number

QUEST 875 GREENTREE RD, 4
DIAGNOSTICS PARKWAY CENTER

PITTSBURGH, PA
15220

607-936-
0146

10/13/2018	86039
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Associated Procedure:
#Result149223359

Text:
ANA TITER (10/13/2018 12:26 AM EDT)

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
	Procedure	Anti-Nuclear Ab 1:160 Titer (A) ANA Pattern (A) Comment: Homogeneous pattern is associated with systemic lupus erythematosus (SLE), drug-induced lupus and juvenile idiopathic arthritis.		<1:40 TITER	QUEST DIAGNOSTICS	
		Specimen Blood specimen (specimen) - Blood - Veni				
		Narrative Performing Organization Information: Site ID: P Name: QUEST DIAGNOSTICS Address: 875 GREENTREE ROAD, 4 PARKWAY CENTER PITTSBURGH, PA 15220 Director: KAMBIZ MERATI, MD				Performed At QUEST DIAGNOSTICS
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146	
	ANA Pat Ser IF-Imp	Value: HOMOGENEOUS Interpretation: A Text: ANA Pattern HOMOGENEOUS (A) Comment: Homogeneous pattern is associated with systemic lupus erythematosus (SLE), drug-induced lupus and juvenile idiopathic arthritis.				
	ANA Titr Ser IF	Value: 1:160 Ref Range: <1:40 TITER Interpretation: A Text: Anti-Nuclear Ab Titer 1:160 <1:40 TITER (A)				
09/26/2018	35261					
	Associated Procedure: #Result148258605 Procedure					
	Unknown	Text: XR SHOULDER MIN 2 VIEWS LEFT (STANDARD) (09/26/2018 10:27 AM EDT) Specimen				

Date	Test	Impression(s)	Performed At
		<p>Impression:</p> <p>No acute osseous or articular abnormality evident.</p> <p>Signed by Luke Ballard on 9/26/2018 10:27 AM</p> <p>Narrative</p> <p>Procedure(s): XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)</p> <p>Date of service: 9/24/2018 1:34 PM</p> <p>Provided clinical information: 41 years, Female, "pain"</p> <p>Procedure and materials: 3 view left shoulder.</p> <p>Comparison studies: 3/22/2018.</p> <p>Observations:</p> <p>Bones: Intact with no displaced fracture or focal osseous destruction.</p> <p>Joints: There is anatomic alignment of the glenohumeral and acromioclavicular joints with normal joint spaces.</p> <p>Soft tissues: Unremarkable.</p> <p>Procedure Note</p> <p>Interface, Rad Results - 09/26/2018 10:29 AM EDT</p> <p>Procedure(s): XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)</p> <p>Date of service: 9/24/2018 1:34 PM</p> <p>Provided clinical information: 41 years, Female, "pain"</p> <p>Procedure and materials: 3 view left shoulder.</p> <p>Comparison studies: 3/22/2018.</p> <p>Observations:</p> <p>Bones: Intact with no displaced fracture or focal osseous destruction.</p> <p>Joints: There is anatomic alignment of the glenohumeral and acromioclavicular joints with normal joint spaces.</p> <p>Soft tissues: Unremarkable.</p> <p>IMPRESSION</p> <p>Impression:</p> <p>No acute osseous or articular abnormality evident.</p> <p>Signed by Luke Ballard on 9/26/2018 10:27 AM</p>	<p>EXHIBIT NO. B2F</p> <p>PAGE: 245 OF 309</p> <p>569</p>
09/14/2018	ESR Bld Qn 15M		
	ESR Bld Qn 15M	Value: 14 mm	

Date	Test	Ref Range	Text	EXHIBIT NO. B2F PAGE: 246 OF 309
	Associated Procedure: ESR Bld Qn 15M	ESR 14 0 - 20 mm	GUTHRIE MEDICAL GROUP LABORATORY	
		Text: SEDIMENTATION RATE (09/14/2018 12:48 PM EDT)		
		Component Value	Ref Range	Performed At
		ESR 14	0 - 20 mm	GUTHRIE MEDICAL GROUP LABORATORY
			Specimen	Pathologist Signature
		Blood specimen (specimen) - Blood - Veni		
		Performing Organization	Address	City/State/Zipcode
		GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840
				Phone Number 570-887-4719
09/14/2018	Comp Metab 2000 Pnl SerPI			
	A/G Ratio	Value: 1.2 Ref Range: 0.8 - 2.0 Text: A/G Ratio 1.2 0.8 - 2.0	GUTHRIE MEDICAL GROUP LABORATORY	
	ALP SerPI-cCnc	Value: 49 U/L Ref Range: 40 - 150 U/L Text: Alkaline Phosphatase 49 40 - 150 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
	ALT SerPI-cCnc	Value: 57 U/L Ref Range: 9 - 52 U/L Interpretation: H Text: ALT 57 9 - 52 U/L (H)	GUTHRIE MEDICAL GROUP LABORATORY	
	AST SerPI-cCnc	Value: 43 U/L Ref Range: 15 - 46 U/L Text: AST 43 15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
	Albumin SerPI-mCnc	Value: 4.1 g/dL Ref Range: 3.5 - 5.0 g/dL Text: Albumin 4.1 3.5 - 5.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	Anion Gap	Value: 9 mmol/L Ref Range: 3 - 11 mmol/L Text: Anion Gap 9 3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
	BUN SerPI-mCnc	Value: 18 mg/dL Ref Range: 7 - 17 mg/dL Interpretation: H Text: BUN 18 7 - 17 mg/dL (H)	GUTHRIE MEDICAL GROUP LABORATORY	
	BUN/Creatinine Ratio	Value: 23 Ref Range: 6 - 22 Interpretation: H Text: BUN/Creatinine Ratio 23 6 - 22 (H)	GUTHRIE MEDICAL GROUP LABORATORY	
	Bilirub SerPI-mCnc	Value: 0.4 mg/dL Ref Range: 0.0 - 1.1 mg/dL Text: Total Bilirubin 0.4 0.0 - 1.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
	CO2 SerPI-sCnc	Value: 29 mmol/L Ref Range: 22 - 30 mmol/L Text: CO2 29 22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	570

Date	Test	Value	Ref Range	Specimen	Performing Organization	Address	City/State/Zipcode	Phone Number
	ALP (H)	49	40 - 150 U/L					
	Alkaline Phosphatase							
	eGFR	>60	See Interpretation Below ml/min/1.73ml Sq					
	Comment:	<p>Estimated GFR Interpretation: Above 60ml/min/1.73m2 = Normal Renal Function 30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease</p> <p>The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:</p> <p>https://www.kidney.org/content/mrd-study-equation</p>						
	BUN/Creatinine Ratio (H)	23	6 - 22					
	Anion Gap	9	3 - 11 mmol/L					
	A/G Ratio	1.2	0.8 - 2.0					
	<p>Specimen Blood specimen (specimen) - Blood - Veni</p> <p>Performing Organization GUTHRIE MEDICAL GROUP LABORATORY</p> <p>Address 1 GUTHRIE SQUARE</p> <p>City/State/Zipcode SAYRE, PA 18840</p> <p>Phone Number 570-887-4719</p>							
	Creat SerPI-mCnc	<p>Value: 0.8 mg/dL Ref Range: 0.7 - 1.2 mg/dL Text: Creatinine 0.8 0.7 - 1.2 mg/dL GUTHRIE MEDICAL GROUP LABORATORY</p>						
	GFR/BSA.pred SerPI MDRD-ArVRat	<p>Value: >60 Ref Range: See Interpretation Below ml/min/1.73ml Sq Text:</p>						

Date	Test																			
		<div>See Interpretation: Below ml/min/1.73m² Sq</div> <div>GUTHRIE MEDICAL GROUP LABORATORY</div> <div>Comment:</div> <div>Estimated GFR Interpretation: Above 60ml/min/1.73m² = Normal Renal Function 30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m² = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/mrd-study-equation</div>																		
	Glucose SerPI-mCnc	Value: 106 mg/dL Ref Range: 70 - 99 mg/dL Interpretation: H Text: Glucose 106 70 - 99 mg/dL (H) GUTHRIE MEDICAL GROUP LABORATORY																		
	Potassium SerPI-sCnc	Value: 4.3 mmol/L Ref Range: 3.5 - 5.1 mmol/L Text: Potassium 4.3 3.5 - 5.1 mmol/L GUTHRIE MEDICAL GROUP LABORATORY																		
	Prot SerPI-mCnc	Value: 7.5 g/dL Ref Range: 6.3 - 8.2 g/dL Text: Total Protein 7.5 6.3 - 8.2 g/dL GUTHRIE MEDICAL GROUP LABORATORY																		
	Sodium SerPI-sCnc	Value: 140 mmol/L Ref Range: 134 - 145 mmol/L Text: Sodium 140 134 - 145 mmol/L GUTHRIE MEDICAL GROUP LABORATORY																		
09/14/2018	CRP SerPI-mCnc																			
	CRP SerPI-mCnc	Value: <0.50 Ref Range: <1.00 mg/dL Text: C-Reactive Protein <0.50 <1.00 mg/dL GUTHRIE MEDICAL GROUP LABORATORY																		
	Associated Procedure: CRP SerPI-mCnc	Text: C-REACTIVE PROTEIN (09/14/2018 12:30 PM EDT) <table><tr><th>Component</th><th>Value</th><th>Ref Range</th><th>Performed At</th><th>Pathologist Signature</th></tr><tr><td>C-Reactive Protein</td><td><0.50</td><td><1.00 mg/dL</td><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td></td></tr></table> Specimen Blood specimen (specimen) - Blood - Veni <table><tr><th>Performing Organization</th><th>Address</th><th>City/State/Zipcode</th><th>Phone Number</th></tr><tr><td>GUTHRIE MEDICAL GROUP LABORATORY</td><td>1 GUTHRIE SQUARE</td><td>SAYRE, PA 18840</td><td>570-887-4719</td></tr></table>	Component	Value	Ref Range	Performed At	Pathologist Signature	C-Reactive Protein	<0.50	<1.00 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY		Performing Organization	Address	City/State/Zipcode	Phone Number	GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
Component	Value	Ref Range	Performed At	Pathologist Signature																
C-Reactive Protein	<0.50	<1.00 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY																	
Performing Organization	Address	City/State/Zipcode	Phone Number																	
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719																	
09/14/2018	85025																			
	Associated Procedure: #Result147121821	Text: CBC WITH DIFFERENTIAL (09/14/2018 12:06 PM EDT) <div>573</div>																		

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
	Procedure	<div>Case 6:21-cv-06188-LGF Document 1-1 Filed 08/27/23 Page 578 of 1112</div> <div>EXHIBIT NO. B2F</div> <div>PAGE: 250 OF 309</div>				
		WBC Count	9.9	3.6 - 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		RBC Count	4.51	3.80 - 5.20 M/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hemoglobin	13.9	12.0 - 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Hematocrit	41.5	35.0 - 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		MCV	91.8	80.0 - 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY	
		MCH	30.8	26.0 - 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY	
		MCHC	33.5	32.0 - 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
		Platelet Count	276	150 - 400 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		MPV	7.6	7.1 - 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY	
		RDW	13.1	11.0 - 15.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil % (H)	89.2	38.0 - 70.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte % (L)	8.5	21.0 - 49.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte %	2.0	1 - 11 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Eosinophil %	0.1	0.0 - 7.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil %	0.2	0.0 - 2.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
		Neutrophil # (H)	8.9	1.8 - 7.7 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Lymphocyte # (L)	0.8	1.0 - 5.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Monocyte #	0.2	0.0 - 0.8 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Eosinophil #	0.0	0.0 - 0.5 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Basophil #	0.0	0.0 - 0.2 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen				
		Blood specimen (specimen) - Blood - Veni				
		Performing Organization		Address	City/State/Zipcode	Phone Number
		GUTHRIE MEDICAL GROUP LABORATORY		1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
	Basophils # Bld Auto	Value: 0.0 K/uL Ref Range: 0.0 - 0.2 K/uL Text: Basophil # 0.0 0.0 - 0.2 K/uL GUTHRIE MEDICAL GROUP LABORATORY				
	Basophils NFr Bld Auto	Value: 0.2 % Ref Range: 0.0 - 2.0 % Text: Basophil % 0.2 0.0 - 2.0 % GUTHRIE MEDICAL GROUP LABORATORY				
	Eosinophil # Bld Auto	Value: 0.0 K/uL Ref Range: 0.0 - 0.5 K/uL Text: Eosinophil # 0.0 0.0 - 0.5 K/uL GUTHRIE MEDICAL GROUP LABORATORY				

Date	Test	Value	Ref Range	Text
	Eosinophil NFr Bld Auto	0.1 %	0.0 - 7.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	Hct VFr Bld Auto	41.5 %	35.0 - 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	Hgb Bld-mCnc	13.9 g/dL	12.0 - 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes # Bld Auto	0.8 K/uL	1.0 - 5.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Lymphocytes NFr Bld Auto	8.5 %	21.0 - 49.0 %	GUTHRIE MEDICAL GROUP LABORATORY
	MCHC RBC Auto-mCnc	30.8 pg	26.0 - 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY
	MCV RBC Auto	33.5 g/dL	32.0 - 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	0.2 K/uL	0.0 - 0.8 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes # Bld Auto	91.8 fL	80.0 - 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY
	Monocytes NFr Bld Auto	2.0 %	1 - 11 %	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils # Bld Auto	8.9 K/uL	1.8 - 7.7 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils # Bld Auto	7.6 fL	7.1 - 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY
	Neutrophils NFr Bld Auto	89.2 %	38.0 - 70.0 %	GUTHRIE MEDICAL GROUP LABORATORY

Date	Test	
	PBG 24h Ur-Mkate	Value: 9.9 K/uL Ref Range: 3.6 - 11.0 K/uL Text: WBC Count 9.9 3.6 - 11.0 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	Prot C PPP Chro-aCnc	Value: 276 K/uL Ref Range: 150 - 400 K/uL Text: Platelet Count 276 150 - 400 K/uL GUTHRIE MEDICAL GROUP LABORATORY
	RDW RBC Auto-Rto	Value: 4.51 M/uL Ref Range: 3.80 - 5.20 M/uL Text: RBC Count 4.51 3.80 - 5.20 M/uL GUTHRIE MEDICAL GROUP LABORATORY
	WBC nRBC cor # Bld Auto	Value: 13.1 % Ref Range: 11.0 - 15.0 % Text: RDW 13.1 11.0 - 15.0 % GUTHRIE MEDICAL GROUP LABORATORY
08/24/2018	34975	

	Associated Procedure: #Result146848612 Procedure	
	Unknown	<p>Text: XR FOOT MIN 3 VIEWS LEFT (STANDARD) (08/24/2018 5:16 PM EDT)</p> <p style="text-align: center;">Specimen</p> <p style="text-align: center;">Impressions</p> <p style="text-align: right;">Performed At</p> <p>Observations and Impression:</p> <p>There is no acute fracture or dislocation. Mi neralization is preserved. The soft tissues are unremarkable.</p> <p>Recommendation: No specific imaging recommendation.</p> <p>Thank you for this kind referral,</p> <p>SAREL GAUR MD Diagnostic and Interventional Radiologist</p> <p>c 570.423.2146</p> <p>Signed by Sarel Gaur on 8/24/2018 5:16 PM</p> <p style="text-align: center;">Narrative</p> <p style="text-align: right;">Performed At</p> <p>Procedure(s): XR FOOT MIN 3 VIEWS LEFT (STANDARD)</p> <p>Date of service: 8/23/2018 11:49 AM</p> <p>Provided clinical information: 41 years, Female, "left foot pain"</p> <p>Procedure and materials: Standard protocol.</p> <p>Side: Left</p> <p>Comparison studies: October 28, 2016</p> <p style="text-align: center;">Procedure Note</p> <p>Interface, Rad Results - 08/24/2018 5:18 PM EDT</p> <p>Procedure(s): XR FOOT MIN 3 VIEWS LEFT (STANDARD)</p> <p>Date of service: 8/23/2018 11:49 AM</p> <p>Provided clinical information: 41 years, Female, "left foot pain"</p>

Date	Test	
		<p>Procedure and materials: Standard protocol.</p> <p>Side: Left</p> <p>Comparison studies: October 28, 2016</p> <p>IMPRESSION</p> <p>Observations and Impression:</p> <p>There is no acute fracture or dislocation. Mineralization is preserved. The soft tissues are unremarkable.</p> <p>Recommendation: No specific imaging recommendation.</p> <p>Thank you for this kind referral,</p> <p>SAREL GAUR MD Diagnostic and Interventional Radiologist</p> <p>c 570.423.2146</p> <p>Signed by Sarel Gaur on 8/24/2018 5:16 PM</p>
08/16/2018	26057	
	Associated Procedure: #Result145420920 Procedure	
	Unknown	<p>Text:</p> <p>US PELVIC COMPLETE WITH EV PROBE (08/16/2018 4:32 PM EDT)</p> <p>Specimen</p> <p>Impressions</p> <p>Performed At</p> <p>IMPRESSION:</p> <p>There is an endometrioma involving the left ovary. This is new as compared back to prior examination. Follow-up in 12 weeks needed. (SRU 2009)</p> <p>Urgency: Routine. This is a routine medical imaging report.</p> <p>Recommendation: No specific imaging recommendation.</p> <p>Signed by Ronald V Hublall, MD, FRCPC, FACR on 8/16/2018 4:32 PM</p>

Date	Test	Narrative	Performed At
		<p>Procedure(s): US PELVIC COMPLETE WITH EV PROBE</p> <p>Date of service: 8/13/2018 11:47 AM</p> <p>Provided clinical information: 41 years, Female, "Adnexal mass, US simple cyst, follow up"</p> <p>Procedure and materials: Greyscale and color doppler images obtained.</p> <p>Comparison studies: May 26, 2018</p> <p>Observations:</p> <p>TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal</p> <p>UTERUS: anteverted and smooth in configuration; Measurement: 6.8 x 3.2 x 4.2 cm.</p> <p>MASSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none</p> <p>ENDOMETRIAL STRIPE: 8 mm. Within normal limits.</p> <p>RIGHT OVARY: Measurement: 3.8 x 2.4 x 3.1 cm. Blood flow is noted within the right ovary. Prior right ovarian cyst has resolved.</p> <p>LEFT OVARY: Measurement: 4.1 x 3.5 x 2.2 cm. Blood flow is noted within the left ovary. 1.6 cm simple cyst involving the left ovary.</p> <p>This within normal limits for patient menstrual age. There is a 2.6 cm endometrioma is present involving the left ovary. Follow-up in 12 weeks recommended. MASSES OR CYSTS IN THE ADNEXA: none</p> <p>FLUID IN THE CUL-DE-SAC: none</p> <p>OTHER: none</p> <p>Procedure Note</p> <p>Interface, Rad Results - 08/16/2018 4:34 PM EDT</p> <p>Procedure(s): US PELVIC COMPLETE WITH EV PROBE</p> <p>Date of service: 8/13/2018 11:47 AM</p> <p>Provided clinical information: 41 years, Female, "Adnexal mass, US simple cyst, follow up"</p> <p>Procedure and materials: Greyscale and color doppler images obtained.</p> <p>Comparison studies: May 26, 2018</p> <p>Observations:</p> <p>TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal</p> <p>UTERUS: anteverted and smooth in configuration; Measurement: 6.8 x</p>	<p>EXHIBIT NO: B2F</p> <p>PAGE: 254 OF 309</p> <p>578</p>

Date	Test	
		<p>3.2 x 4.2 cm.</p> <p>MASSSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none</p> <p>ENDOMETRIAL STRIPE: 8 mm. Within normal limits.</p> <p>RIGHT OVARY: Measurement: 3.8 x 2.4 x 3.1 cm. Blood flow is noted within the right ovary. Prior right ovarian cyst has resolved.</p> <p>LEFT OVARY: Measurement: 4.1 x 3.5 x 2.2 cm. Blood flow is noted within the left ovary. 1.6 cm simple cyst involving the left ovary.</p> <p>This within normal limits for patient menstrual age. There is a 2.6 cm endometrioma is present involving the left ovary. Follow-up in 12 weeks recommended. MASSSES OR CYSTS IN THE ADNEXA: none</p> <p>FLUID IN THE CUL-DE-SAC: none</p> <p>OTHER: none</p> <p>IMPRESSION</p> <p>IMPRESSION:</p> <p>There is an endometrioma involving the left ovary. This is new as compared back to prior examination. Follow-up in 12 weeks needed. (SRU 2009)</p> <p>Urgency: Routine. This is a routine medical imaging report.</p> <p>Recommendation: No specific imaging recommendation.</p> <p>Signed by Ronald V Hublall, MD, FRCPC, FACR on 8/16/2018 4:32 PM</p>
08/14/2018	Folate+Vit B12 SerBld-Imp	
	Folate SerPI-mCnc	<p>Value: 14.1 ng/mL</p> <p>Ref Range: 2.8 - 20.0 ng/mL</p> <p>Text:</p> <p>Folate 14.1 2.8 - 20.0 ng/mL GUTHRIE MEDICAL GROUP LABORATORY</p>
	Associated Procedure: Folate+Vit B12 SerBld-Imp	<p>Text:</p> <p>VITAMIN B12 / FOLATE (08/14/2018 2:06 PM EDT)</p>

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
		Vitamin B12	374	239 - 931 pg/mL	GUTHRIE MEDICAL GROUP LABORATORY	EXHIBIT NO. B2F PAGE: 256 OF 309
		Folate	14.1	2.8 - 20.0 ng/mL	GUTHRIE MEDICAL GROUP LABORATORY	
		Specimen Blood specimen (specimen) - Blood - Veni				
		Performing Organization		Address	City/State/Zipcode	Phone Number
		GUTHRIE MEDICAL GROUP LABORATORY		1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719
	Vitamin B12	Value: 374 pg/mL Ref Range: 239 - 931 pg/mL Text: Vitamin B12 374 239 - 931 pg/mL GUTHRIE MEDICAL GROUP LABORATORY				
08/10/2018	34927					
	Associated Procedure: #Result145420916 Procedure					
	Unknown	Text: XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD) (08/10/2018 3:37 PM EDT) Specimen Impressions IMPRESSION: Normal right thumb. Urgency: Routine. This is a routine medical imaging report. Recommendation: No specific imaging recommendation. Signed by Barry Skeist, MD on 8/10/2018 3:37 PM Narrative Procedure(s): XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD) Date of service: 8/8/2018 9:50 AM Provided clinical information: 41 years, Female, "pain" Procedure and materials: Standard protocol. Comparison studies: 10/7/2014 Observations: 3 views of right thumb show bones to be intact. Bony relationships are normal. No erosions or calcifications or foreign bodies. Mineralization is normal. Procedure Note Interface, Rad Results - 08/10/2018 3:39 PM EDT Procedure(s): XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD) Date of service: 8/8/2018 9:50 AM Provided clinical information: 41 years, Female, "pain" Procedure and materials: Standard protocol.				

580

Date	Test	Impressions	Performed At
		<p>Impression:</p> <p>No acute osseous or articular abnormality evident. Negative knee.</p> <p>Signed by Luke Ballard on 7/10/2018 2:56 AM</p>	<p>EXHIBIT NO. B2F</p> <p>PAGE: 258 OF 309</p>
		<p>Narrative</p> <p>Procedure(s): XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)</p> <p>Date of service: 7/6/2018 12:25 PM</p> <p>Provided clinical information: 41 years, Female, "right knee pain"</p> <p>Procedure and materials: Standard protocol.</p> <p>Comparison studies: 3/22/2018</p> <p>Observations:</p> <p>Side: 4 views of the right knee.</p> <p>Bones: Intact with no displaced fracture or focal osseous destruction.</p> <p>Joints: There is anatomic alignment with normal joint spaces.</p> <p>Soft tissues: Unremarkable.</p>	<p>Performed At</p>
		<p>Procedure Note</p> <p>Interface, Rad Results - 07/10/2018 2:58 AM EDT</p> <p>Procedure(s): XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)</p> <p>Date of service: 7/6/2018 12:25 PM</p> <p>Provided clinical information: 41 years, Female, "right knee pain"</p> <p>Procedure and materials: Standard protocol.</p> <p>Comparison studies: 3/22/2018</p> <p>Observations:</p> <p>Side: 4 views of the right knee.</p> <p>Bones: Intact with no displaced fracture or focal osseous destruction.</p> <p>Joints: There is anatomic alignment with normal joint spaces.</p> <p>Soft tissues: Unremarkable.</p> <p>IMPRESSION</p> <p>Impression:</p> <p>No acute osseous or articular abnormality evident. Negative knee.</p> <p>Signed by Luke Ballard on 7/10/2018 2:56 AM</p>	<p>582</p>

Date	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 587 of 1112		EXHIBIT NO. B2F
			PAGE: 259 OF 309
07/06/2018	29312		
	Associated Procedure: #Result144400428 Procedure		
	Unknown	<p>Text: JOINT ASPIRATION/INJECTION (07/06/2018 9:20 AM EDT)</p> <p>Narrative Performed At</p> <p>This result has an attachment that is not available.</p> <p>Harbison, Alicia, DO 7/6/2018 10:47 AM</p> <p>Joint Aspiration/Injection</p> <p>Date/Time: 7/6/2018 10:46 AM</p> <p>Performed by: HARBISON, ALICIA</p> <p>Authorized by: HARBISON, ALICIA</p> <p>Indications: pain</p> <p>Body area: knee</p> <p>Joint: right knee</p> <p>Local anesthesia used: yes</p> <p>Anesthesia:</p> <p>Local anesthesia used: yes</p> <p>Local Anesthetic: lidocaine 1% without epinephrine</p> <p>Sedation:</p> <p>Patient sedated: no</p> <p>Needle size: 22 G</p> <p>Ultrasound guidance: no</p> <p>Fluoroscopy guidance: no</p> <p>Approach: lateral</p> <p>Aspirate: clear</p> <p>Aspirate amount: 0.5 mL</p> <p>Patient tolerance: Patient tolerated the procedure well with no immediate complications</p> <p>Comments: Dr. Garcia-Ryan was present for the entire procedure.</p> <p>Procedure Note</p> <p>Harbison, Alicia, DO - 07/06/2018 9:20 AM EDT</p>	
			583

Date	Test	
		<p>PATIENT: Jennifer Lynn Brown</p> <p>MRN: 340616</p> <p>DOB: 10/26/1976</p> <p>DATE OF SERVICE: 7/6/2018</p> <p>Joint Aspiration/Injection</p> <p>Date/Time: 7/6/2018 10:46 AM</p> <p>Performed by: HARBISON, ALICIA</p> <p>Authorized by: HARBISON, ALICIA</p> <p>Indications: pain</p> <p>Body area: knee</p> <p>Joint: right knee</p> <p>Local anesthesia used: yes</p> <p>Anesthesia:</p> <p>Local anesthesia used: yes</p> <p>Local Anesthetic: lidocaine 1% without epinephrine</p> <p>Sedation:</p> <p>Patient sedated: no</p> <p>Needle size: 22 G</p> <p>Ultrasound guidance: no</p> <p>Fluoroscopy guidance: no</p> <p>Approach: lateral</p> <p>Aspirate: clear</p> <p>Aspirate amount: 0.5 mL</p> <p>Patient tolerance: Patient tolerated the procedure well with no immediate complications</p> <p>Comments: Dr. Garcia-Ryan was present for the entire procedure.</p> <p>Author: Alicia Harbison, DO 7/6/2018 10:46</p>
06/25/2018	153249	
	Associated Procedure: #Result143349308 Procedure	

Date	Test
	<div data-bbox="203 37 1607 73" data-label="Page-Header"> <div>Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 589 of 1112</div> <div>EXHIBIT NO. B2F PAGE: 261 OF 309</div> </div> <div data-bbox="203 73 1607 2079" data-label="Text"> <div>Unknown</div> <div>Text:</div> <div>MAMMO SCREENING TOMOSYNTHESIS BILATERAL (06/25/2018 2:00 PM EDT)</div> <div>Specimen</div> <div>Impressions</div> <div>Performed At</div> <div>Impression: Benign findings. No mammographic evidence of malignancy.</div> <div>BI-RADS Assessment Category: Category 2: Benign.</div> <div>Management Recommendation: Routine annual screening mammography per ACR and SBI guidelines.</div> <div>Urgency: Routine. This is a routine medical imaging report.</div> <div>Signed by Shereef Ramadan on 6/25/2018 2:00 PM</div> <div>Narrative</div> <div>Performed At</div> <div>Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL</div> <div>Date of service: 6/25/2018 11:42 AM</div> <div>Provided clinical information: 41 years, Female, "Routine".</div> <div>Procedure and materials: Bilateral 2D digital mammography and 3D Digital Breast Tomosynthesis in CC and MLO projections were obtained. 2D images were analyzed by a CAD system.</div> <div>Comparison studies: Prior mammograms dated 6/5/2017, 11/30/2016 and 11/21/2016.</div> <div>Most recent clinical breast exam: May 2018.</div> <div>Observations:</div> <div>Breast composition: There are scattered areas of fibroglandular density.</div> <div>Mass: None.</div> <div>Calcifications: None.</div> <div>Architectural Distortion: None.</div> <div>Asymmetries: Stable asymmetries in both breasts.</div> <div>Other pertinent findings: None.</div> <div>Procedure Note</div> <div>Interface, Rad Results - 06/25/2018 2:02 PM EDT</div> <div>Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL</div> <div>Date of service: 6/25/2018 11:42 AM</div> <div>Provided clinical information: 41 years, Female, "Routine".</div> <div>Procedure and materials: Bilateral 2D digital mammography and 3D Digital Breast Tomosynthesis in CC and MLO projections were obtained.</div> </div>

Date	Test
	<p>2D images were analyzed by a CAD system.</p> <p>Comparison studies: Prior mammograms dated 6/5/2017, 11/30/2016 and 11/21/2016.</p> <p>Most recent clinical breast exam: May 2018.</p> <p>Observations:</p> <p>Breast composition: There are scattered areas of fibroglandular density.</p> <p>Mass: None.</p> <p>Calcifications: None.</p> <p>Architectural Distortion: None.</p> <p>Asymmetries: Stable asymmetries in both breasts.</p> <p>Other pertinent findings: None.</p> <p>IMPRESSION</p> <p>Impression: Benign findings. No mammographic evidence of malignancy.</p> <p>BI-RADS Assessment Category: Category 2: Benign.</p> <p>Management Recommendation: Routine annual screening mammography per ACR and SBI guidelines.</p> <p>Urgency: Routine. This is a routine medical imaging report.</p> <p>Signed by Shereef Ramadan on 6/25/2018 2:00 PM</p>

Narrative Text

● CBC WITH DIFFERENTIAL (06/06/2019 11:02 AM EDT)					
Component	Value	Ref Range	Performed At	Pathologist Signature	
WBC Count	8.97	3.98 – 10.04 K/uL	GUTHRIE MEDICAL GROUP LABORATORY		
RBC Count	4.64	3.93 – 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY		
Hemoglobin	13.5	11.2 – 15.7 G/DL	GUTHRIE MEDICAL GROUP LABORATORY		

Component		Value	Ref Range	Performed At	Pathologist Signature
Hematocrit		34.1	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY	
MCV	89.9		79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY	
MCH	29.1		25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY	
MCHC	32.4		32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Platelet Count	348		182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
MPV	9.4		9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY	
RDW	13.1		11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil %	60.8		34.0 - 71.1 %	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte %	25.0		19.3 - 51.7 %	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte %	10.1		4.7 - 12.5 %	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil %	3.1		0.7 - 5.8 %	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil %	0.6		0.1 - 1.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
nRBC %	0.0		0.0 - 0.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil #	5.45		1.56 - 6.13 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte #	2.24		1.18 - 3.74 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte #	0.91 (H)		0.24 - 0.86 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil #	0.28		0.04 - 0.36 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil #	0.05		0.01 - 0.08 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Immature Gran %	0.4		0.0 - 0.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
Immature Gran #	0.04 (H)		0.00 - 0.03 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
NRBC #	0.00		0.00 - 0.12 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	

Blood

Performing Organization**Address****City/State/Zipcode****Phone Number**GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

EXHIBIT NO. B2F
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- VITAMIN D 25-HYDROXY (GUTHRIE) (06/06/2019 12:14 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Vitamin D-25 HYDROXY	32.0	32.0 – 100.0 ng/ml	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood

Narrative**Performed At**

Interpretation:

GUTHRIE MEDICAL
GROUP LABORATORY

<20 ng/ml — Deficiency

20 – <30 ng/ml — Insufficiency

32 – 100 ng/ml — Sufficiency

>100 ng/ml — Potential Toxicity

Performing Organization**Address****City/State/Zipcode****Phone Number**GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

- C-REACTIVE PROTEIN (GUTHRIE) (06/06/2019 12:57 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
C-Reactive Protein	0.80	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood

Performing Organization**Address****City/State/Zipcode****Phone Number**GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

- COMPREHENSIVE METABOLIC PANEL (GUTHRIE) (06/06/2019 12:57 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Sodium	137	134 – 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Potassium	4.5	3.5 – 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Chloride	103	98 – 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
CO2	26	22 – 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Calcium	8.9	8.3 – 10.1 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Albumin	4.1	3.5 – 5.0 g/dl	GUTHRIE MEDICAL GROUP LABORATORY	
BUN	13	7 – 17 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Creatinine	0.8	0.7 – 1.2 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Glucose	84	70 – 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	

Component	Value	Ref Range	Performed At	Pathologist Signature
Total Protein	6.4	6.0 - 8.2 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Total Bilirubin	0.3	0.0 - 1.1 MG/DL	GUTHRIE MEDICAL GROUP LABORATORY	
AST	29	15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
ALT	27	9 - 52 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
Alkaline Phosphatase	51	40 - 150 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
eGFR	>60	See Interpretation-Below ml/min/1.73ml-Sq	GUTHRIE MEDICAL GROUP LABORATORY	
Comment:				
Estimated GFR Interpretation: Above 60ml/min/1.73m2 = Normal Renal Function 30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease 15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at: https://www.kidney.org/content/m-drds-study-equation				
BUN/Creatinine Ratio	16	6 - 22 RATIO	GUTHRIE MEDICAL GROUP LABORATORY	
Anion Gap	8	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
A/G Ratio	1.2	0.8 - 2.0 ratio	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- SEDIMENTATION RATE (06/06/2019 11:37 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
ESR	11	0 - 20 MM/HR	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- SIGN PERMIT (05/24/2019 12:00 PM EDT)

- Nerve Block (05/24/2019 7:41 AM EDT)

Narrative

Chopra, Nitin, MD 5/24/2019 7:42 AM

Nerve Block

Date/Time: 5/24/2019 7:34 AM

Performed by: Chopra, Nitin, MD

Authorized by: Chopra, Nitin, MD

Universal protocol

Consent obtained: Written

Consent provided by: Patient _____

Risks/benefits discussed with: Patient _____

Time out performed: Yes

Consents match procedure: Yes

Pre-Procedure

Indications: post-op pain management _____

Preadmission anticoagulation therapy:

Location

Body area: Upper extremity

Upper Extremity: Interscalene

Sedation/Analgesia

Yes _____

Level of sedation:

Sedation type: anxiolysis _____

Sedation: Midazolam and see MAR for details

Vital signs monitored during sedation Vital signs monitored during
sedation

Procedure Details

Preparation: Patient was prepped and draped in usual sterile fashion _____

Prep Solution: Chloraprep _____

Patient position: Beach chair

Skin Infiltration Drug: lidocaine 1%

Needle gauge: 22 G

Needle type: Echogenic

Needle length(cm): 5.0

Location technique: Ultrasound-guided

Local anesthetic: Ropivacaine 0.5%

Anesthetic total (ml): 25

Injection Made Incrementally in mL: 2

Post procedure

Outcome/Complications: Positive block

Patient tolerance: Patient tolerated the procedure well with no immediate complications

Vitals monitored during the procedure: Patient observed

Comments

- URINE PREGNANCY (POCT) (05/24/2019 6:30 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Urine Pregnancy Test (POCT)	negative		POINT-OF CARE TESTING	
Qualitative Urine HCG Internal Control (POCT)	acceptable		POINT-OF CARE TESTING	
	Comment:			
	Performed at: Robert Packer Hospital POCT Dilip Gupta MD, Laboratory Medical Director 1 Guthrie Square Sayre, PA 18840			

Performing Organization	Address	Specimen	City/State/Zipcode	Phone Number
POINT-OF CARE TESTING				

- STREP A ANTIGEN (AMB POCT) (05/15/2019)

Component	Value	Ref Range	Performed At	Pathologist Signature
Strep A Antigen (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
Control Line	Present	Present	GUTHRIE CLINIC POCT	
Strep A Antigen Confirm (POCT)	Yes, Sent for Confirmation		GUTHRIE CLINIC POCT	
Lot Number	191127		GUTHRIE CLINIC POCT	
Expiration Date	8/31/20		GUTHRIE CLINIC POCT	

Performing Organization	Address	Specimen	City/State/Zipcode	Phone Number
GUTHRIE CLINIC POCT	1 Guthrie Square		Sayre, PA 18840	

- THROAT STREP SCREEN CULTURE (05/17/2019 11:11 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Throat Strep Screen Culture	No pathogenic beta hemolytic Streptococci cultured		GUTHRIE MEDICAL GROUP LABORATORY	

Performing Organization	Address	Specimen	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	Throat	SAYRE, PA 18840	570-887-4719

- BASIC METABOLIC PANEL (05/06/2019 2:50 PM EDT)

Glucose		70–130 mg/dl		
BUN	11	7–17 mg/dl		
Creatinine	0.7	0.7–1.2 mg/dl		
Sodium	139	134–145 mmol/L		
Potassium	4.3	3.5–5.1 mmol/L		
Chloride	102	98–107 mmol/L		
CO2	29	22–30 mmol/L		
Calcium	9.0	8.3–10.1 mg/dl		
eGFR	>60	See Interpretation Below ml/min/1.73m ² Sq		
Comment:				

Estimated GFR Interpretation:
 Above 60ml/min/1.73m² = Normal
 Renal Function
 30-59 ml/min/1.73m² = Stage 3
 Chronic Kidney Disease
 15-29 ml/min/1.73m² = Stage 4
 Chronic Kidney Disease
 Less than 15 ml/min/1.73m² = Stage 5
 Chronic Kidney Disease

The GFR value is calculated using the
 Modification of Diet in Renal Disease
 (MDRD) Study Equation which can be
 found at:

<https://www.kidney.org/content/m-dr-d-study-equation>

BUN/Creatinine Ratio	16	6–22 RATIO		
Anion Gap	8	3–11 mmol/L		

Specimen

Blood				
Performing Organization	Address	City/State/Zip code	Phone Number	
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719	

- CBC-NO DIFFERENTIAL (05/06/2019 2:28 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
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WBC Count	12.3	3.98 - 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
Comment: Methodology was changed 1/3/2019. Please note updated reference range and units.			
RBC Count	4.57	3.93 - 5.22 M/uL	GUTHRIE MEDICAL GROUP LABORATORY
Hemoglobin	13.5	11.2 - 15.7 G/DL	GUTHRIE MEDICAL GROUP LABORATORY
Hematocrit	41.1	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY
MCV	89.9	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY
MCH	29.5	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY
MCHC	32.8	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY
Platelet Count	345	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY
MPV	9.4	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY
RDW	13.0	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY

Specimen

Blood			
Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- REFER TO SLEEP STUDY LAB (05/02/2019)

Specimen

Narrative

Performed At

This result has an attachment that is not available.

Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie.

- CT HEAD WITHOUT IV CONTRAST (04/18/2019 3:52 PM EDT)

Specimen

Impressions

Performed At

IMPRESSION:

No acute intracranial findings.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM

Procedure(s): ~~CT Head with Intravenous Contrast~~

Date of service: 4/18/2019 3:29 PM

Provided clinical information: 42 years, Female, "Headache, acute,
norm-neuro-exam: sent by family practice for CT"

Procedure and materials: Standard protocol.

Contrast: None.

Comparison studies: 7/17/2008.

Observations:—

There is no midline shift or mass effect. CSF spaces appear normal for
age. No pathologic fluid collections are seen. No acute intracranial
hemorrhage is noted.—

The gray-white matter differentiation is well preserved. There is no
evidence for an acute transcortical or vascular territorial infarct.—

There is no depressed calvarial fracture. The skull base and
surrounding soft tissues appear unremarkable.—

Procedure(s): CT HEAD WITHOUT IV CONTRAST

Date of service: 4/18/2019 3:29 PM

Provided clinical information: 42 years, Female, "Headache, acute,

norm-neuro exam: sent by family practice for CT"

Procedure and materials: Standard protocol.

Contrast: None.

Comparison studies: 7/17/2008.

Observations:

There is no midline shift or mass effect. CSF spaces appear normal for

age. No pathologic fluid collections are seen. No acute intracranial

hemorrhage is noted.

The gray-white matter differentiation is well preserved. There is no

evidence for an acute transcortical or vascular territorial infarct.

There is no depressed calvarial fracture. The skull base and

surrounding soft tissues appear unremarkable.

IMPRESSION

IMPRESSION:

No acute intracranial findings.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM

- REFER TO SLEEP STUDY LAB (03/29/2019)

Specimen

Narrative

Performed At

This result has an attachment that is not available.

Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie.

- XR ELBOW 2 VIEWS RIGHT (02/11/2019 4:12 PM EST)

Specimen

Unremarkable exam.

Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM

Narrative

Performed At

Procedure(s): XR ELBOW 2 VIEWS RIGHT

Date of service: 2/7/2019 3:36 PM

Provided clinical information: 42 years, Female, "pain"

Procedure and materials: 2 images of the right elbow were obtained.

Comparison studies: None.

Observations:

No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.

Procedure Note

Interface, Rad Results - 02/11/2019 4:15 PM EST

Procedure(s): XR ELBOW 2 VIEWS RIGHT

Date of service: 2/7/2019 3:36 PM

Provided clinical information: 42 years, Female, "pain"

Procedure and materials: 2 images of the right elbow were obtained.

Comparison studies: None.

Observations:

No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.

IMPRESSION

Impression:

Unremarkable exam.

Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM

- HEPATITIS B SURFACE ANTIBODY (01/23/2019 11:33 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
Hepatitis B Surface Antibody	274.00	See Result Interpretation for Immune Status mIU/ml	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Vitros Test Result: <5.00 mIU/ml Negative or Non-Immune

>=5.00 and <12.0 mIU/ml Indeterminate*

>=12.0 mIU/ml Positive or Immune

*Note for Indeterminate Results:

It is recommended that a new specimen be obtained in two weeks and retested.

Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

• VARICELLA ZOSTER ANTIBODY IGG (01/24/2019 4:39 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
Varicella Zoster Ab Igg	1201.00	INDEX	QUEST DIAGNOSTICS	

Comment:

INDEX VALUE RESULTS
 INTERPRETATION

<135.00 Negative Negative
 Result: Antibody not
 detected

135.00-164.99 Equivocal Equivocal
 result: Consider
 re-testing on a new
 specimen

>=165.00 Positive Sample is
 considered positive
 for IgG antibodies to
 VZV virus

A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection.

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization	Address	City/State/Zipcode	Phone Number
QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146

• CBC WITH DIFFERENTIAL (01/17/2019 1:17 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
WBC Count	13.5	3.98 - 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Comment: Methodology was changed 1/3/2019. Please note updated reference range and units.				
RBC Count	4.46	3.93 - 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Hemoglobin	13.4	11.2 - 15.7 G/DL	GUTHRIE MEDICAL GROUP LABORATORY	
Hematocrit	41.6	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY	
MCV	93.3	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY	
MCH	30.0	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY	
MCHC	32.2	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Platelet Count	310	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
MPV	9.8	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY	
RDW	12.4	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil %	62.2	34.0 - 71.1 %	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte %	26.6	19.3 - 51.7 %	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte %	8.2	4.7 - 12.5 %	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil %	2.0	0.7 - 5.8 %	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil %	0.7	0.1 - 1.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
nRBC %	0.0	0.0 - 0.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil #	6.18 (H)	1.56 - 6.13 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte #	2.65	1.18 - 3.74 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte #	0.82	0.24 - 0.86 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil #	0.20	0.04 - 0.36 K/UL	GUTHRIE MEDICAL GROUP LABORATORY	

Basophil #	0.0	0.0-1.0 %		
Immature Gran %	0.3	0.0-0.4 %		
Immature Gran #	0.03	0.00-0.03 K/uL		
NRBC #	0.00	0.00-0.12 K/uL		

GUTHRIE
MEDICAL GROUP
LABORATORY
GUTHRIE
MEDICAL GROUP
LABORATORY
GUTHRIE
MEDICAL GROUP
LABORATORY

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

- VITAMIN D 25-HYDROXY (GUTHRIE) (01/17/2019 1:53 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
Vitamin D-25 HYDROXY	31.8 (L)	32.0-100.0 ng/ml	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Narrative

Performed At

Interpretation:

GUTHRIE MEDICAL
GROUP LABORATORY

<20 ng/ml - Deficiency

20-<30 ng/ml - Insufficiency

32-100 ng/ml - Sufficiency

>100 ng/ml - Potential Toxicity

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

- C-REACTIVE PROTEIN (01/17/2019 1:45 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
C-Reactive Protein (H)	1.10 (H)	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

- COMPREHENSIVE METABOLIC PANEL (01/17/2019 1:45 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
Sodium	139	134-145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Potassium	4.2	3.5-5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Chloride	104	98-107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
CO2	27	22-30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	

Calcium

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Albumin

3.9

3.5 – 5.0 g/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

BUN

14

7 – 17 mg/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

Creatinine

1.0

0.7 – 1.2 mg/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

Glucose

101
(H)

70 – 99 mg/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

Total Protein

7.3

6.3 – 8.2 g/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

Total Bilirubin

0.1

0.0 – 1.1 mg/dl

GUTHRIE
MEDICAL GROUP
LABORATORY

AST

34

15 – 46 U/L

GUTHRIE
MEDICAL GROUP
LABORATORY

ALT

28

9 – 52 U/L

GUTHRIE
MEDICAL GROUP
LABORATORYAlkaline
Phosphatase

62

40 – 150 U/L

GUTHRIE
MEDICAL GROUP
LABORATORY

eGFR

>60

See Interpretation Below
ml/min/1.73m² SqGUTHRIE
MEDICAL GROUP
LABORATORY

Comment:

Estimated GFR Interpretation:

Above 60ml/min/1.73m² = Normal

Renal Function

30-59 ml/min/1.73m² = Stage 3

Chronic Kidney Disease

15-29 ml/min/1.73m² = Stage 4

Chronic Kidney Disease

Less than 15 ml/min/1.73m² = Stage 5

Chronic Kidney Disease

The GFR value is calculated using the
Modification of Diet in Renal Disease
(MDRD) Study Equation which can be
found at:<https://www.kidney.org/content/m-dr-d-study-equation>BUN/Creatinine
Ratio

14

6 – 22

GUTHRIE
MEDICAL GROUP
LABORATORY

Anion Gap

8

3 – 11 mmol/L

GUTHRIE
MEDICAL GROUP
LABORATORY

A/G Ratio

1.1

0.8 – 2.0

GUTHRIE
MEDICAL GROUP
LABORATORY

Specimen

Blood specimen (specimen) – Blood – Veni

GUTHRIE MEDICAL GROUP - 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

EXHIBIT NO. B2F

PAGE: 277 OF 309

- SEDIMENTATION RATE (01/17/2019 1:46 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
ESR	14	0-20 MM/HR	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization	Address	City/State/Zipco de	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- URINE DIP MANUAL (AMB POCT) (12/21/2018)

Component	Value	Ref Range	Performed At	Pathologist Signature
URINE GLUCOSE (POCT)	Negative	Negative mg/dl	GUTHRIE CLINIC POCT	
URINE BILIRUBIN (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
Urine Ketones (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
URINE SPECIFIC GRAVITY (POCT)	1.015	1.005-1.030	GUTHRIE CLINIC POCT	
URINE BLOOD (POCT)	Trace-Intact (A)	Negative	GUTHRIE CLINIC POCT	
URINE PH (POCT)	6.0	5.0-8.0	GUTHRIE CLINIC POCT	
URINE PROTEIN (POCT)	Negative	Negative mg/dl	GUTHRIE CLINIC POCT	
URINE UROBILINOGEN (POCT)	0.2	0.2-1.0 mg/dl	GUTHRIE CLINIC POCT	
URINE NITRITES (POCT)	Negative	Negative	GUTHRIE CLINIC POCT	
URINE LEUKOCYTES (POCT)	Small (A)	Negative	GUTHRIE CLINIC POCT	

Specimen

Performing Organization	Address	City/State/Zipco de	Phone Number
GUTHRIE CLINIC POCT	1 Guthrie Square	Sayre, PA 18840	

- URINE CULTURE (C&S) (12/22/2018 1:58 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
Urine Culture	No growth of clinical significance		GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Urine specimen (specimen) - URINE CLEAN CATCH

Performing Organization	Address	City/State/Zipco de	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- MR PELVIS W AND WO CONTRAST (12/23/2018 2:44 PM EST)

Specimen

Follicles are seen involving both ovaries, within normal limits for a patient of reproductive age. Of note there is a 23 mm right ovarian corpus luteal cyst. There is no definitive MR evidence for a endometrioma involving the left ovary, as previously suggested on ultrasound.

RECOMMENDATION:

No specific imaging recommendation.

Thank you for this kind referral,

SAREL GAUR MD | Diagnostic and Interventional Radiologist

e 570.423.2146

Signed by Sarel Gaur on 12/23/2018 2:44 PM

PROCEDURE(S): MR PELVIS W AND WO CONTRAST

(Contrast Enhanced MR of the Pelvis)

DATE OF SERVICE: 12/13/2018 6:38 PM

PROVIDED CLINICAL INFORMATION: 42 years, Female, "Adnexal mass, US
complex or solid mass, follow up: rule out endometrioma"——

PROCEDURE AND MATERIALS: Standard protocol. (multiplanar multisequence
MR imaging of the pelvis was obtained)

CONTRAST: IV contrast only.

COMPARISON STUDIES: Ultrasound dated November 8, 2018 and report from
August 13, 2018

OBSERVATIONS:

VESSELS: Normal caliber aorta.

REPRODUCTIVE ORGANS: Several cysts are seen involving both ovaries,
more prominent involving the right ovary. There is a 23 mm right
ovarian peripherally hyperenhancing cyst most compatible with a corpus
luteal cyst.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: No aggressive lesions.

ABDOMINAL WALL: Unremarkable.

Procedure Note

Interface, Rad Results – 12/23/2018 2:46 PM EST

PROCEDURE(S): MR PELVIS W AND WO CONTRAST

(Contrast Enhanced MR of the Pelvis)

DATE OF SERVICE: 12/13/2018 6:38 PM

e-570-423-2146

Signed by Sarel Gaur on 12/23/2018 2:44 PM

● CBC WITH DIFFERENTIAL (11/12/2018 12:37 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
WBC Count	11.6 (H)	3.6 – 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
RBC Count	4.69	3.80 – 5.20 M/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Hemoglobin	14.2	12.0 – 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Hematocrit	43.2	35.0 – 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
MCV	92.1	80.0 – 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY	
MCH	30.2	26.0 – 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY	
MCHC	32.8	32.0 – 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Platelet Count	343	150 – 400 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
MPV	7.6	7.1 – 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY	
RDW	13.0	11.0 – 15.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil %	59.4	38.0 – 70.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte %	28.6	21.0 – 49.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte %	8.8	1 – 11 %	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil %	2.3	0.0 – 7.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil %	0.9	0.0 – 2.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil #	6.9	1.8 – 7.7 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte #	3.3	1.0 – 5.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	

Component		Value	Ref Range	Performed At	Pathologist Signature
Monocyte #	0.0	(H)	0.0 - 1.8 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil #	0.3		0.0 - 0.5 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil #	0.1		0.0 - 0.2 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

• COMPREHENSIVE METABOLIC PANEL (11/12/2018 1:04 PM EST)

Component		Value	Ref Range	Performed At	Pathologist Signature
Sodium	141		134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Potassium	4.0		3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Chloride	103		98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
CO2	29		22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Calcium	8.9		8.3 - 10.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Albumin	4.0		3.5 - 5.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
BUN	14		7 - 17 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Creatinine	0.7		0.7 - 1.2 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Glucose	105	(H)	70 - 99 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Total Protein	7.3		6.3 - 8.2 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Total Bilirubin	0.3		0.0 - 1.1 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	
AST	37		15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
ALT	36		9 - 52 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
Alkaline Phosphatase	49		40 - 150 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
eGFR	>60		See Interpretation Below ml/min/1.73ml Sq	GUTHRIE MEDICAL GROUP LABORATORY	
Comment:					

Estimated GFR Interpretation:
 Above 60ml/min/1.73m2 = Normal
 Renal Function
 30-59 ml/min/1.73m2 = Stage 3
 Chronic Kidney Disease
 15-29 ml/min/1.73m2 = Stage 4
 Chronic Kidney Disease
 Less than 15 ml/min/1.73m2 = Stage 5
 Chronic Kidney Disease

The GFR value is calculated using the
 Modification of Diet in Renal Disease
 (MDRD) Study Equation which can be
 found at:

<https://www.kidney.org/content/m-dr-d-study-equation>

BUN/Creatinine Ratio	20	6–22	GUTHRIE MEDICAL GROUP LABORATORY
Anion Gap	9	3–11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
A/G Ratio	1.2	0.8–2.0	GUTHRIE MEDICAL GROUP LABORATORY

Specimen

Blood specimen (specimen) – Blood – Veni			
Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

- US PELVIC COMPLETE WITH EV PROBE (11/14/2018 3:45 AM EST)

Specimen

Impressions

Performed At

IMPRESSION:

There is a minimally complex right ovarian cystic lesion favoring an evolving hemorrhagic cyst.

Size stable echogenic lesion of the left ovary. An MRI of the pelvis with and without intravenous contrast could be acquired to exclude an endometrioma if warranted.

Additionally, there is apparent cystic change within the nonthickened endometrium. Possibly representing a focus of evolving cystic endometrial hyperplasia. Tissue sampling could be acquired for further characterization and to exclude other less common etiologies.

Otherwise, attention at routine imaging follow-up is requested.

Signed by Patrick Dyer, MD on 11/14/2018 3:45 AM

Procedure(s): US PELVIC COMPLETE WITH EV PROBE

Date of service: 11/8/2018 11:05 AM

History: 42 years, Female, "Follow up endometrioma left ovary"

Technique: A transabdominal and transvaginal sonogram of the pelvis was performed using color and grayscale technique.

Findings:

Uterus: The uterus demonstrates normal parenchymal echotexture and echogenicity. The endometrial-myometrial junction is well-maintained.

The uterus measures 7.2 x 2.9 x 3.8 cm.

Endometrium: There are tiny anechoic cysts within the endometrium. The endometrium is not thickened (Time stamp 11: 21: 18, A.M.). Small minimally-complicated nabothian cysts are seen along the cervix. The lower uterine segment is otherwise within normal limits. The endometrium measures 8 mm when measured accurately.

Ovaries: There is a 2.0 cm circumscribed right ovarian cyst containing thickened internal-septations and a nodular echogenic component along its anterolateral border, new since prior examination. There is a 1.8 x 1.7 cm x 2.0 circumscribed, homogeneously echogenic left renal lesion, previously measuring 2.1 cm. (Time stamp 11: 27: 11, A.M.).

Spectral interrogation of the ovaries was not performed.

The right ovary measures 4.6 x 2.1 x 2.8 cm.

The left ovary measures 3.6 x 2.8 x 2.0 cm.

Adnexa: There are no adnexal masses or significant free fluid.

Procedure Note

Interface, Rad Results -- 11/14/2018 3:47 AM EST

Procedure(s): US PELVIC COMPLETE WITH EV PROBE

Date of service: 11/8/2018 11:05 AM

History: 42 years, Female, "Follow up endometrioma left ovary"

Technique: A transabdominal and transvaginal sonogram of the pelvis was performed using color and grayscale technique.

Findings:

Uterus: The uterus demonstrates normal parenchymal echotexture and

echogenicity. The endometrial-myometrial junction is well-maintained.

The uterus measures 7.2 x 2.9 x 3.8 cm.

Endometrium: There are tiny anechoic cysts within the endometrium. The

endometrium is not thickened (Time stamp 11: 21: 18, A.M.). Small

minimally-complicated nabothian cysts are seen along the cervix. The

lower uterine segment is otherwise within normal limits. The

endometrium measures 8 mm when measured accurately.

Ovaries: There is a 2.0 cm circumscribed right ovarian cyst containing

thickened internal septations and a nodular echogenic component along

its anterolateral border, new since prior examination. There is a 1.8

x 1.7 cm x 2.0 circumscribed, homogeneously echogenic left renal

lesion, previously measuring 2.1 cm. (Time stamp 11: 27: 11, A.M.).

Spectral interrogation of the ovaries was not performed.

The right ovary measures 4.6 x 2.1 x 2.8 cm.

The left ovary measures 3.6 x 2.8 x 2.0 cm.

Adnexa: There are no adnexal masses or significant free fluid.

IMPRESSION

IMPRESSION:

There is a minimally complex right ovarian cystic lesion favoring an evolving hemorrhagic cyst.

Size stable echogenic lesion of the left ovary. An MRI of the pelvis with and without intravenous contrast could be acquired to exclude an endometrioma if warranted.

Additionally, there is apparent cystic change within the nonthickened endometrium. Possibly representing a focus of evolving cystic endometrial hyperplasia. Tissue sampling could be acquired for further

characterization grade exclude other less common etiologies.

Otherwise, attention at routine imaging follow-up is requested.

Signed by Patrick Dyer, MD on 11/14/2018 3:45 AM

- EMG/NCV (11/09/2018)

Narrative	Specimen	Performed At
This result has an attachment that is not available.		

Even though this test was performed at a Guthrie facility, the means of getting the information into your Electronic Health Record does not allow the results to be accessible within eGuthrie.

- ANA TITER (10/13/2018 12:26 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Anti-Nuclear Ab Titer	1:160 (A)	<1:40 TITER	QUEST DIAGNOSTICS	
ANA Pattern	HOMOGENEOUS (A)		QUEST DIAGNOSTICS	

Comment:

Homogeneous pattern is associated with systemic lupus erythematosus (SLE), drug-induced lupus and juvenile idiopathic arthritis.

Narrative	Specimen	Performed At
Blood specimen (specimen) -- Blood -- Veni		
Performing Organization Information:		QUEST DIAGNOSTICS

— Site ID: P

— Name: QUEST DIAGNOSTICS

— Address: 875 GREENTREE ROAD, 4 PARKWAY CENTER PITTSBURGH, PA 15220

— Director: KAMBIZ MERATI, MD

Performing Organization	Address	City/State/Zipcode	Phone Number
QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146

- ANTI NUCLEAR ANTIBODY (10/13/2018 12:26 AM EDT)

Comment:

ANA IFA is a first line screen for detecting the presence of up to approximately 150 autoantibodies in various autoimmune diseases. A positive ANA IFA result is suggestive of autoimmune disease and reflexes to titer and pattern. Further laboratory testing may be considered if clinically indicated.

TITER ————— INTERPRETATION

—————
<1:40 ————— NEGATIVE
1:40 – 1:80 ——— LOW ANTIBODY
LEVEL
>1:80 ————— ELEVATED ANTIBODY
LEVEL

Visit Physician FAQs for interpretation of all antibodies in the Cascade, prevalence, and association with diseases at <http://education.questdiagnostics.com/faq/FAQ177>

Specimen

Blood specimen (specimen) – Blood – Veni

Narrative

Performing Organization Information:

Performed At
QUEST DIAGNOSTICS

— Site ID: P

— Name: QUEST DIAGNOSTICS

— Address: 875 GREENTREE ROAD, 4 PARKWAY CENTER PITTSBURGH, PA 15220

— Director: KAMBIZ MERATI, MD

Performing Organization	Address	City/State/Zipcode	Phone Number
QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146

● ANTI HISTONE ANTIBODY (10/13/2018 12:26 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Antihistone Antibody	1.7 (H)	<1.0 U	QUEST DIAGNOSTICS	

Comment:

—————
REFERENCE RANGE:
————— <1.0 ————— Negative
————— 1.0 to 1.5 ——— Weak Positive
————— 1.6 to 2.5 ——— Moderate Positive
————— >2.5 ————— Strong Positive
—————

Specimen

Blood specimen (specimen) – Blood – Veni

Performing Organization Information

— Site ID: G

— Name: QUEST DIAGNOSTICS NICHOLS INSTITUTE

— Address: 14225 NEWBROOK DRIVE CHANTILLY, VA 20151

— Director: PATRICK W MASON, MD, PHD

Performing Organization	Address	City/State/Zipcode	Phone Number
QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146

- XR SHOULDER MIN 2 VIEWS LEFT (STANDARD) (09/26/2018 10:27 AM EDT)

Specimen

Impressions

Performed At

Impression:

No acute osseous or articular abnormality evident.

Signed by Luke Ballard on 9/26/2018 10:27 AM

Narrative

Performed At

Procedure(s): XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)

Date of service: 9/24/2018 1:34 PM

Provided clinical information: 41 years, Female, "pain"

Procedure and materials: 3 view left shoulder.

Comparison studies: 3/22/2018.

Observations: —

Bones: Intact with no displaced fracture or focal osseous destruction.

Joints: There is anatomic alignment of the glenohumeral and

acromioclavicular joints with normal joint spaces.

Soft tissues: Unremarkable.

Procedure(s): XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)

Date of service: 9/24/2018 1:34 PM

Provided clinical information: 41 years, Female, "pain"

Procedure and materials: 3 view left shoulder.

Comparison studies: 3/22/2018.

Observations:

Bones: Intact with no displaced fracture or focal osseous destruction.

Joints: There is anatomic alignment of the glenohumeral and

acromioclavicular joints with normal joint spaces.

Soft tissues: Unremarkable.

IMPRESSION

Impression:

No acute osseous or articular abnormality evident.

Signed by Luke Ballard on 9/26/2018 10:27 AM

• CBC WITH DIFFERENTIAL (09/14/2018 12:06 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
WBC-Count	9.9	3.6 - 11.0 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
RBC-Count	4.51	3.80 - 5.20 M/uL	GUTHRIE MEDICAL GROUP LABORATORY	
Hemoglobin	13.9	12.0 - 16.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Hematocrit	41.5	35.0 - 47.0 %	GUTHRIE MEDICAL GROUP LABORATORY	
MCV	91.8	80.0 - 100.0 fL	GUTHRIE MEDICAL GROUP LABORATORY	
MCH	30.8	26.0 - 34.0 pg	GUTHRIE MEDICAL GROUP LABORATORY	
MCHC	33.5	32.0 - 36.0 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Platelet Count	276	150 - 400 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
MPV	7.6	7.1 - 11.2 fL	GUTHRIE MEDICAL GROUP LABORATORY	

RDW

Neutrophil %	89.2 (H)	38.0 – 70.0 %
Lymphocyte %	8.5 (L)	21.0 – 49.0 %
Monocyte %	2.0	1 – 11 %
Eosinophil %	0.1	0.0 – 7.0 %
Basophil %	0.2	0.0 – 2.0 %
Neutrophil #	8.9 (H)	1.8 – 7.7 K/uL
Lymphocyte #	0.8 (L)	1.0 – 5.0 K/uL
Monocyte #	0.2	0.0 – 0.8 K/uL
Eosinophil #	0.0	0.0 – 0.5 K/uL
Basophil #	0.0	0.0 – 0.2 K/uL

GUTHRIE
MEDICAL GROUP
LABORATORY

GUTHRIE
MEDICAL GROUP
LABORATORY

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GUTHRIE
MEDICAL GROUP
LABORATORY

Specimen

Blood specimen (specimen) – Blood – Veni

Performing Organization**Address****City/State/Zipco de****Phone Number**GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

● C-REACTIVE PROTEIN (09/14/2018 12:30 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
C-Reactive Protein	<0.50	<1.00 mg/dL	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) – Blood – Veni

Performing Organization**Address****City/State/Zipco de****Phone Number**GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

● COMPREHENSIVE METABOLIC PANEL (09/14/2018 12:30 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Sodium	140	134 – 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Potassium	4.3	3.5 – 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Chloride	102	98 – 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	

CO2

Calcium

9.1

8.3 – 10.1 mg/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

Albumin

4.1

3.5 – 5.0 g/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

BUN

18
(H)

7 – 17 mg/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

Creatinine

0.8

0.7 – 1.2 mg/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

Glucose

106
(H)

70 – 99 mg/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

Total Protein

7.5

6.3 – 8.2 g/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

Total Bilirubin

0.4

0.0 – 1.1 mg/dL

GUTHRIE
MEDICAL GROUP
LABORATORY

AST

43

15 – 46 U/L

GUTHRIE
MEDICAL GROUP
LABORATORY

ALT

57
(H)

9 – 52 U/L

GUTHRIE
MEDICAL GROUP
LABORATORYAlkaline
Phosphatase

49

40 – 150 U/L

GUTHRIE
MEDICAL GROUP
LABORATORY

eGFR

>60

See Interpretation Below
ml/min/1.73mL SqGUTHRIE
MEDICAL GROUP
LABORATORY

Comment:

Estimated GFR Interpretation:

Above 60ml/min/1.73m² = Normal

Renal Function

30-59 ml/min/1.73m² = Stage 3

Chronic Kidney Disease

15-29 ml/min/1.73m² = Stage 4

Chronic Kidney Disease

Less than 15 ml/min/1.73m² = Stage 5

Chronic Kidney Disease

The GFR value is calculated using the
Modification of Diet in Renal Disease
(MDRD) Study Equation which can be
found at:

<https://www.kidney.org/content/m-dr-d-study-equation>

BUN/Creatinine
Ratio23
(H)

6 – 22

GUTHRIE
MEDICAL GROUP
LABORATORY

Anion Gap

9

3 – 11 mmol/L

GUTHRIE
MEDICAL GROUP
LABORATORY

A/G Ratio

1.2

0.8 – 2.0

GUTHRIE
MEDICAL GROUP
LABORATORY

Performing Organization**Address****City/State/Zipcode****Phone Number**

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

EXHIBIT NO. B2F
PAGE: 292 OF 309

- SEDIMENTATION RATE (09/14/2018 12:48 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
ESR	14	0 - 20 mm	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) - Blood - Veni

Performing Organization**Address****City/State/Zipcode****Phone Number**

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
LABORATORY

SAYRE, PA 18840

570-887-4719

- XR FOOT MIN 3 VIEWS LEFT (STANDARD) (08/24/2018 5:16 PM EDT)

Specimen**Impressions****Performed At**

Observations and Impression:—

There is no acute fracture or dislocation. Mi neralization is

preserved. The soft tissues are unremarkable.

Recommendation: No specific imaging recommendation.

Thank you for this kind referral,

SAREL GAUR MD | Diagnostic and Interventional Radiologist

e 570.423.2146

Signed by Sarel Gaur on 8/24/2018 5:16 PM

Narrative**Performed At**

Procedure(s): XR FOOT MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/23/2018 11:49 AM

Provided clinical information: 41 years, Female, "left foot pain"

Procedure and materials: Standard protocol.

Side: Left

Comparison studies: October 28, 2016

Procedure(s): XR FOOT MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/23/2018 11:49 AM

Provided clinical information: 41 years, Female, "left foot pain"

Procedure and materials: Standard protocol.

Side: Left

Comparison studies: October 28, 2016

IMPRESSION

Observations and Impression:

There is no acute fracture or dislocation. Mineralization is preserved. The soft tissues are unremarkable.

Recommendation: No specific imaging recommendation.

Thank you for this kind referral,

SAREL GAUR MD | Diagnostic and Interventional Radiologist

e 570.423.2146

Signed by Sarel Gaur on 8/24/2018 5:16 PM

● VITAMIN B12 / FOLATE (08/14/2018 2:06 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Vitamin B12	374	239—931 pg/mL	GUTHRIE MEDICAL GROUP LABORATORY	
Folate	14.1	2.8—20.0 ng/mL	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood specimen (specimen) — Blood — Veni

Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

● US PELVIC COMPLETE WITH EV PROBE (08/16/2018 4:32 PM EDT)

Specimen

There is an endometrioma involving the left ovary. This is new as compared back to prior examination. Follow-up in 12 weeks needed. (SRU 2009)

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Ronald V Hubball, MD, FRCPC, FACR on 8/16/2018 4:32 PM

Narrative

Performed At

Procedure(s): US PELVIC COMPLETE WITH EV PROBE

Date of service: 8/13/2018 11:47 AM

Provided clinical information: 41 years, Female, "Adnexal mass, US simple cyst, follow up"

Procedure and materials: Greyscale and color doppler images obtained.

Comparison studies: May 26, 2018

Observations:—

TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal

UTERUS: anteverted and smooth in configuration;—Measurement: 6.8 x 3.2 x 4.2 cm.

MASSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none

ENDOMETRIAL STRIPE: 8 mm. Within normal limits.

RIGHT OVARY: Measurement: 3.8 x 2.4 x 3.1 cm. Blood flow is noted within the right ovary. Prior right ovarian cyst has resolved.

LEFT OVARY: Measurement: 4.1 x 3.5 x 2.2 cm. Blood flow is noted within the left ovary. 1.6 cm simple cyst involving the left ovary.

This within normal limits for patient menstrual age. There is a 2.6 cm endometrioma is present involving the left ovary. Follow-up in 12 weeks recommended. MASSES OR CYSTS IN THE ADNEXA: none

FLUID IN THE CUL-DE-SAC: none

OTHER: none

Procedure Note

Interface, Rad Results—08/16/2018 4:34 PM EDT

Procedure(s): US PELVIC COMPLETE WITH EV PROBE

Date of service: 8/13/2018 11:47 AM

Provided clinical information: 41 years, Female, "Adnexal mass, US

simple cyst, follow-up.

Procedure and materials: Greyscale and color doppler images obtained.

Comparison studies: May 26, 2018

Observations:

TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal

UTERUS: anteverted and smooth in configuration; Measurement: 6.8 x 3.2 x 4.2 cm.

MASSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none

ENDOMETRIAL STRIPE: 8 mm. Within normal limits.

RIGHT OVARY: Measurement: 3.8 x 2.4 x 3.1 cm. Blood flow is noted within the right ovary. Prior right ovarian cyst has resolved.

LEFT OVARY: Measurement: 4.1 x 3.5 x 2.2 cm. Blood flow is noted within the left ovary. 1.6 cm simple cyst involving the left ovary.

This within normal limits for patient menstrual age. There is a 2.6 cm endometrioma is present involving the left ovary. Follow-up in 12 weeks recommended. MASSES OR CYSTS IN THE ADNEXA: none

FLUID IN THE CUL-DE-SAC: none

OTHER: none

IMPRESSION

IMPRESSION:

There is an endometrioma involving the left ovary. This is new as compared back to prior examination. Follow-up in 12 weeks needed. (SRU 2009)

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

- XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD) (08/10/2018 3:37 PM EDT)

Specimen

Impressions

Performed At

IMPRESSION:

Normal right thumb.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Barry Skeist, MD on 8/10/2018 3:37 PM

Narrative

Performed At

Procedure(s): XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD)

Date of service: 8/8/2018 9:50 AM

Provided clinical information: 41 years, Female, "pain"

Procedure and materials: Standard protocol.

Comparison studies: 10/7/2014

Observations:—

3 views of right thumb show bones to be intact. Bony relationships are

normal. No erosions or calcifications or foreign bodies.

Mineralization is normal.

Procedure(s): XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD)

Date of service: 8/8/2018 9:50 AM

Provided clinical information: 41 years, Female, "pain"

Procedure and materials: Standard protocol.

Comparison studies: 10/7/2014

Observations:

3 views of right thumb show bones to be intact. Bony relationships are

normal. No erosions or calcifications or foreign bodies.

Mineralization is normal.

IMPRESSION

IMPRESSION:

Normal right thumb.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Barry Skeist, MD on 8/10/2018 3:37 PM

- XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD) (07/10/2018 2:56 AM EDT)

Specimen

Impressions

Performed At

Impression:

No acute osseous or articular abnormality evident. Negative knee.

Signed by Luke Ballard on 7/10/2018 2:56 AM

Procedure(s): XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)

Date of service: 7/6/2018 12:25 PM

Provided clinical information: 41 years, Female, "right knee pain"

Procedure and materials: Standard protocol.

Comparison studies: 3/22/2018

Observations:

Side: 4 views of the right knee.

Bones: Intact with no displaced fracture or focal osseous destruction.

Joints: There is anatomic alignment with normal joint spaces.

Soft tissues: Unremarkable.

Procedure Note

Interface, Rad Results - 07/10/2018 2:58 AM EDT

Procedure(s): XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)

Date of service: 7/6/2018 12:25 PM

Provided clinical information: 41 years, Female, "right knee pain"

Procedure and materials: Standard protocol.

Comparison studies: 3/22/2018

Observations:

Side: 4 views of the right knee.

Bones: Intact with no displaced fracture or focal osseous destruction.

Joints: There is anatomic alignment with normal joint spaces.

Soft tissues: Unremarkable.

IMPRESSION

Impression:

No acute osseous or articular abnormality evident. Negative knee.

Signed by Luke Ballard on 7/10/2018 2:56 AM

● ANAEROBIC CULTURE (C&S) (07/11/2018 8:19 AM EDT)

Component	Value
Anaerobic Culture	No Growth Aerobic/Anaerobic in 5 days

Ref Range

Performed At	Pathologist Signature
GUTHRIE MEDICAL GROUP LABORATORY	622

Component**Value****Ref Range****Performed At****Pathologist Signature**

Gram Stain

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GUTHRIE

MEDICAL GROUP

LABORATORY

EXHIBIT NO. B2F
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Gram Stain

No Organisms Observed

GUTHRIE

MEDICAL GROUP

LABORATORY

Specimen

Wound swab (specimen) -- KNEE RIGHT

Performing Organization**Address****City/State/Zipcode****Phone Number**GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

- JOINT ASPIRATION/INJECTION (07/06/2018 9:20 AM EDT)

Harbison, Alicia, DO — 7/6/2018 10:47 AM

Joint Aspiration/Injection

Date/Time: 7/6/2018 10:46 AM

Performed by: HARBISON, ALICIA

Authorized by: HARBISON, ALICIA

Indications: pain

Body area: knee

Joint: right knee

Local anesthesia used: yes

Anesthesia:

Local anesthesia used: yes

Local Anesthetic: lidocaine 1% without epinephrine

Sedation:

Patient sedated: no

Needle size: 22 G

Ultrasound guidance: no

Fluoroscopy guidance: no

Approach: lateral

Aspirate: clear

Aspirate amount: 0.5 mL

Patient tolerance: Patient tolerated the procedure well with no immediate complications

Comments: Dr. Garcia-Ryan was present for the entire procedure.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 7/6/2018

Joint Aspiration/Injection

Date/Time: 7/6/2018 10:46 AM

Performed by: HARBISON, ALICIA

Authorized by: HARBISON, ALICIA

Indications: pain

Body area: knee

Joint: right knee

Local anesthesia used: yes

Anesthesia:

Local anesthesia used: yes

Local Anesthetic: lidocaine 1% without epinephrine

Sedation:

Patient sedated: no

Needle size: 22 G

Ultrasound guidance: no

Fluoroscopy guidance: no

Approach: lateral

Aspirate: clear

Aspirate amount: 0.5 mL

Patient tolerance: Patient tolerated the procedure well with no immediate complications

Comments: Dr. Garcia-Ryan was present for the entire procedure.

Author: Alicia Harbison, DO 7/6/2018 10:46

625

Impression: Benign findings. No mammographic evidence of malignancy.

BI-RADS Assessment Category: Category 2: Benign.

Management Recommendation: Routine annual screening mammography per ACR and SBI guidelines.—

Urgency: Routine. This is a routine medical imaging report.

Signed by Shereef Ramadan on 6/25/2018 2:00 PM

Narrative

Performed At

Procedure(s): MAMMO-SCREENING-TOMOSYNTHESIS-BILATERAL

Date of service: 6/25/2018 11:42 AM

Provided clinical information: 41 years, Female, "Routine".

Procedure and materials: Bilateral 2D digital mammography and 3D

Digital Breast Tomosynthesis in CC and MLO projections were obtained.

2D images were analyzed by a CAD system.

Comparison studies: Prior mammograms dated 6/5/2017, 11/30/2016 and 11/21/2016.

Most recent clinical breast exam: May 2018.

Observations:

Breast composition: There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: Stable asymmetries in both breasts.

Other pertinent findings: None.

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Date of service: 6/25/2018 11:42 AM

Provided clinical information: 41 years, Female, "Routine".

Procedure and materials: Bilateral 2D digital mammography and 3D

Digital Breast Tomosynthesis in CC and MLO projections were obtained.

2D images were analyzed by a CAD system.

Comparison studies: Prior mammograms dated 6/5/2017, 11/30/2016 and 11/21/2016.

Most recent clinical breast exam: May 2018.

Observations:

Breast composition: There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: Stable asymmetries in both breasts.

Other pertinent findings: None.

IMPRESSION

Impression: Benign findings. No mammographic evidence of malignancy.

BI-RADS Assessment Category: Category 2: Benign.

Management Recommendation: Routine annual screening mammography per

ACR and SBI guidelines.

Urgency: Routine. This is a routine medical imaging report.

Signed by Shereef Ramadan on 6/25/2018 2:00 PM

VITALS

Vital Signs

<u>Type</u>	<u>Date</u>	<u>Interpretation</u>	<u>Value</u>	<u>Ref Range</u>
BP dias	06/20/2019		80 mm[Hg]	
BP sys	06/20/2019		118 mm[Hg]	
Bdy height	06/20/2019		180.3 cm	
Body temperature	06/20/2019		37.78 Cel	
Heart rate	06/20/2019		102 /min	
Resp rate	06/20/2019		18 /min	
SaO2 % BldA PulseOx	06/20/2019		97 %	
Weight	06/20/2019		129.729 kg	

<u>Narrative Text</u>			
<u>Vital Sign</u>	<u>Reading</u>	<u>Time Taken</u>	<u>Comments</u>
Blood Pressure	118 / 80	06/20/2019 3:17 PM EDT	
Pulse	102	06/20/2019 3:17 PM EDT	
Temperature	37.8 °C (100 °F)	06/20/2019 3:17 PM EDT	
Respiratory Rate	18	06/20/2019 3:17 PM EDT	
Oxygen Saturation	97%	06/20/2019 3:17 PM EDT	
Inhaled Oxygen Concentration	-	-	
Weight	129.7 kg (286 lb)	06/20/2019 3:17 PM EDT	
Height	180.3 cm (5' 11")	06/20/2019 3:17 PM EDT	
Body Mass Index	39.89	06/20/2019 3:17 PM EDT	

MEDS

Medication Information

Non-identified Provider

<u>Date</u>	<u>Product</u>	<u>Indication</u>	<u>Status</u>	<u>Dose</u>	<u>Frequency</u>	<u>Quantity</u>
06/26/2019	183860	Diagnosis interpretation	Inactive	90 mg	Unknown	
06/20/2019	0228-2027-10		Active	0.25 mg	Unknown	15
05/30/2019	53746-109-01		Active	1 {tbl}	Unknown	40
05/24/2019	0406-0552-01		Active	5 mg	Unknown	20
05/24/2019	10135-144-05		Inactive	1000 mg	Unknown	30
05/24/2019	60505-0113-1		Active	300 mg	Unknown	5
05/15/2019	0093-3160-06		Inactive	300 mg	Every .5d	20
05/15/2019	0172-5413-46		Active	200 mg	Unknown	2
05/09/2019	0054-4728-25		Inactive		Unknown	50
04/15/2019	0378-6689-10		Active	40 mg	Unknown	90
04/15/2019	0378-2075-01	Diagnosis interpretation	Active	20 mg	Unknown	90
04/15/2019	10370-102-03	Diagnosis interpretation	Active	300 mg	Unknown	90

<u>Date</u>	<u>Product</u>	<u>Indication</u>	<u>Status</u>	<u>Dose</u>	<u>Frequency</u>	<u>Quantity</u>
04/15/2019	0093-7386-56	Diagnosis interpretation	Active	60 mg	Unknown	90
04/15/2019	0093-7386-56	Diagnosis interpretation	Active	150 mg	Unknown	90
04/15/2019	147869		Active	1 mL	Unknown	12
03/13/2019	94046-00168		Active	1 {each}	Unknown	100
03/11/2019	183860	Diagnosis interpretation	Inactive	90 mg	Unknown	
01/28/2019	69452-151-20		Inactive	50000 U	Unknown	4
01/17/2019	10135-182-01		Active	1 mg	Unknown	30
01/17/2019	69452-151-20		Active	50000 U	Unknown	8
01/07/2019	183860		Inactive	90 mg	Unknown	
12/21/2018	0185-0122-01	Diagnosis interpretation	Inactive	100 mg	Every .5d	10
12/17/2018	171391		Active	1 {application}	Every .5d	1
11/21/2018	11917-01257	Diagnosis interpretation	Active	2 {spray}	Unknown	
10/26/2018	194969		Inactive	520 mg	Unknown	4
10/26/2018	183860	Problem	Active	90 mg	Unknown	1
09/29/2018	0703-3671-01		Active	25 mg	Unknown	12
09/27/2018	129007		Active	25 mg	Unknown	100
09/27/2018	129007		Active	1 mL	Unknown	100
09/20/2018	11917-09905		Active	1 {capsule}	Unknown	90
08/28/2018	68180-857-11	Diagnosis interpretation	Active	1 {tbl}	Unknown	84
08/17/2018	0517-0032-25		Active	1000 ug	Unknown	12
07/31/2018	0703-0063-01	Diagnosis interpretation	Inactive	80 mg	Unknown	
07/06/2018	0409-4276-01	Diagnosis interpretation	Inactive	3 mL	Unknown	
06/21/2018	0517-0032-25	Diagnosis interpretation	Inactive	1000 ug	Unknown	
06/21/2018	182038	Diagnosis interpretation	Active	.3 mg	Unknown	1
05/23/2018	45749-01781		Active	1 {capsule}	Unknown	60
03/13/2018	0054-3270-99	Diagnosis interpretation	Active	2 {spray}	Unknown	1
03/13/2018	0781-5077-01	Diagnosis interpretation	Active	10 mg	Unknown	30
09/05/2017	11917-05038		Active	600 mg	Every .5d	60
02/23/2017	0378-0751-01	Diagnosis interpretation	Active	10 mg	Unknown	42
08/17/2016	0378-7734-93		Active	8 mg	Unknown	30

Narrative Text

<u>Medication</u>	<u>Sig</u>	<u>Dispensed</u>	<u>Refills</u>	<u>Start Date</u>	<u>End Date</u>	<u>Status</u>
ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.	30 Tab	1	08/17/2016		Active
cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.	42 Tab	0	02/23/2017		Active
Indications: Trapezius muscle spasm						
calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.	60 Tab	5	09/05/2017		Active

fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension
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Indications: Nasal congestion						
loratadine (CLARITIN, ALAVER T) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.	30 Tab	0	03/13/2018		Active
Indications: Nasal congestion						
Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn	60 Cap	3	05/23/2018		Active
EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).	1 Each	3	06/21/2018		Active
Indications: Bee sting reaction, accidental or unintentional, initial encounter						
cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.	12 mL	0	08/17/2018	07/14/2019	Active
levonorgestrel-e thinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.	84 Tab	3	08/28/2018		Active
Indications: Encounter for contraceptive management, unspecified type						
Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.	90 Cap	3	09/20/2018		Active
methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 1 mL beneath the skin EVERY SATURDAY.	12 mL	1	09/29/2018		Active
Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate	100 Each	1	09/27/2018		Active
Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly	100 Each	0	09/27/2018		Active
Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.	1 Syringe	5	10/26/2018		Active
Indications: Crohn's Disease						
Nitroglycerin 0.4 % Rectal Ointment	Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.	1 Tube	0	12/17/2018		Active
foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.	30 Tab	5	01/17/2019		Active
ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap	Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.	8 Cap	1	01/17/2019		Active
Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.	100 Each	0	03/13/2019		Active
pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.	90 Tab	1	04/15/2019		Active
lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.	90 Tab	1	04/15/2019		Active

Indications:
HTN (hypertension), benign

Medication

Sig

Dispensed

Refills

Start Date End Date

Status

buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1	04/15/2019	Active
Indications: Depression, unspecified depression type					
venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1	04/15/2019	Active
Indications: GAD (generalized anxiety disorder)					
venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1	04/15/2019	Active
Indications: GAD (generalized anxiety disorder)					
Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days	12 Each	0	04/15/2019	Active
fluconazole (DIFLUCAN) 200 MG Oral Tab	Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10	2 Tab	0	05/15/2019	Active
OXYcodone (OXY-IR,OXY-FAST) 5 MG Oral Tab	Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (pain). Max Daily Amount: 30 mg.	20 Tab	0	05/24/2019	Active
gabapentin (NEURONTIN) 300 MG Oral Cap	Take 1 Cap by mouth EVERY BEDTIME.	5 Cap	0	05/24/2019	Active
HYDROcodone-acet aminophen (NORCO) 5-325 MG Oral Tab	Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (Pain, continued treatment). Max Daily Amount: 6 Tabs.	40 Tab	0	05/30/2019	Active
ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.	15 Tab	0	06/20/2019	Active
ustekinumab (STELARA) 130 MG/26ML Intravenous Solution	104 mL by Intravenous route ONE TIME for 1 dose.	ONE 4 vial	0	10/26/2018	10/27/2018Expired
nitrofurantoin monohydrate macrocrystal (MACROBID) 100 MG Oral Cap	Take 1 Cap by mouth TWICE DAILY for 5 days.	10 Cap	0	12/21/2018	12/26/2018Expired
Indications: Dysuria					
ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap	Take 1 Cap by mouth EVERY 7 DAYS for 4 doses.	4 Cap	0	01/28/2019	02/19/2019Expired
predniSONE (DELTASONE) 5 MG Oral Tab	Take 4 Tabs by mouth DAILY for 5 days, THEN 3 Tabs DAILY for 5 days, THEN 2 Tabs DAILY for 5 days, THEN 1 Tab DAILY for 5 days. Then STOP.	50 Tab	0	05/09/2019	05/29/2019Expired
Cefdinir (OMNICEF) 300 MG Oral Cap	Take 1 Cap by mouth TWICE DAILY for 10 days.	20 Cap	0	05/15/2019	05/25/2019Expired
acetaminophen (TYLENOL) 500 MG Oral Tab	Take 2 Tabs by mouth EVERY EIGHT HOURS for 5 days.	30 Tab	0	05/24/2019	05/29/2019Expired

saline (OCEAN) nasal spray 0.65 2 Spray %	NA	Q2 HRS PRN	11/21/2018	Active
Indications: Acute URI				
cyanocobalamin (VITAMIN B12) injection 1,000 mcg	IM	X1	06/21/2018	06/21/2018Ended
Indications: Vitamin B12 deficiency				
lidocaine (XYLOCAINE) injection 1 %	IJ	X1	07/06/2018	07/13/2018Ended
Indications: Knee swelling				
methyLPREDNISolo ne acetate (DEPO-MEDROL) injection 80 MG/ML	IX	X1	07/31/2018	07/31/2018Ended
Indications: Chronic left shoulder pain				
Ustekinumab 90 MG/ML SOSY (Ordered as: STELARA)	SC	X1	01/07/2019	01/07/2019Ended
Ustekinumab 90 MG/ML SOSY	SC	X1	03/11/2019	03/11/2019Ended
Indications: Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)				
Ustekinumab 90 MG/ML SOSY	SC	X1	06/26/2019	06/26/2019Ended
Indications: Crohn's disease of small intestine with other complication (HCC)				

CARE PLAN

Plan of Care

Narrative Text

Upcoming Encounters				
Date	Type	Specialty	Care Team	Description
07/05/2019	Office Visit		Watson, Brittany, PA	
			1 GUTHRIE SQ	
			SAYRE, PA 18840	
			570-887-2841	
			570-887-2364 (Fax)	
07/10/2019	Office Visit			

Health Maintenance	Due Date	Last Done	Comments
PNEUMOCOCCAL 0-64 YRS (2 of 3 - PCV13)	07/08/2017	07/08/2016	
LIPID DISORDER SCREENING	03/12/2019	03/12/2018, 01/12/2016, 09/03/2015, Additional history exists	
MAMMOGRAM (SCREENING)	06/25/2019	06/25/2018, 06/05/2017, 11/30/2016, Additional history exists	
DEPRESSION SCREENING	01/31/2020	01/31/2019, 01/31/2019	
DIABETES SCREENING	06/06/2020	06/06/2019, 05/06/2019, 01/17/2019, Additional history exists	
PAP SMEAR	04/05/2021	04/05/2018, 06/02/2015, 02/11/2014, Additional history exists	
COLONOSCOPY SCREENING	06/11/2021	06/11/2018, 06/11/2018, 06/02/2017, Additional history exists	
HIV SCREENING	Completed	03/12/2018	
INFLUENZA VACCINE	Completed	10/03/2018, 10/11/2017, 09/22/2016, Additional history exists	
HPV IMMUNIZATION SERIES	Aged Out		No longer eligible based on patient's age to complete this topic
MENINGOCOCCAL VACCINE IMM	Aged Out		No longer eligible based on patient's age to complete this topic

PROV LIST

Healthcare Providers

The Guthrie Clinic (05/01/2015 - No Date Available)

Provider Name	Address	Telecom	MRN
Michael F Gillan, DO	1 GUTHRIE SQUARE SAYRE, PA 18840	tel:+1-570-887-2239, fax:+1-570-887-3285	633
Muhammad Z Khan, MD			

1 4 1 9 0 7 1



FAX: 1-866-323-8335

To:	OTDA-Division	Fax:	1-866-323-8335
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1 4 1 9 0 7 1 2 0 0 0 0 3 0 3



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Fax: 866-323-8335

To: K. RICHARDSON
NYS Office of Temporary and Disability Assistance, Division of Disability
Determinations
PO Box 8783
London, KY 40742-9927
Phone: 800-522-5511x3238

Re: Brown, Jennifer
DOB: 10/26/1976
VSI ID: 6014-106826
Case #: F003D6B53

Records
From: Guthrie - Robert Packer Hospital
Guthrie Square
Sayre, PA 18840

Pages in this distribution (including this cover sheet): 144

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Claimant's Name: JENNIFER L. BROWN

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Date of Birth: 10/26/1976

Medical Record Number/Patient ID: 340616

AKA: Jennifer Lyn Evans

Previous Address:

INFORMATION REQUESTED

PT/OT Notes

MRI and CT Scans

Psychiatric Records

Clinic Notes

Discharge Summary

Admission History

X-Ray Report(s) of All

Please send available medical records including imaging, diagnostics, and testing, from 06/19/17 to present. Thank you.

Dates of treatment

OUTPATIENT

FIRST INPATIENT

MOST RECENT INPATIENT

05/26/2018 - Present



1 4 1 9 0 7 1 2 0 0 0 0 3 0 3



Andrew M. Cuomo
Governor

Office of Temporary and Disability Assistance

Samuel D. Roberts
Commissioner

Sharon Devine
Executive Deputy Commissioner

FAX TRANSMITTAL

To:	ROBERT PACKER HOSPITAL	Fax:	5708875153
From:	OTDA-Division	Re:	Requests for Records
Date:	2019-07-01 10:00:12	Pages:	6 (includes cover sheet)
<input type="checkbox"/> Urgent <input type="checkbox"/> For Review <input type="checkbox"/> Please Comment <input checked="" type="checkbox"/> Please Reply <input type="checkbox"/> Action Needed			
Division of Disability Determinations Fax: 1-866-323-8335 Phone: 1-800-522-5511			

Comments: Please reply at earliest convenience to this request for medical evidence.



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

5/26/2018 6:21 AM	Department Rph Emergency Department	Har	Center RPH
-------------------	---	-----	---------------

ED**5/26/2018****Jennifer Lyn Brown****MRN: 340616****Notes****ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM**

Author: Raftis, James, DO	Service: EMERGENCY MEDICINE	Author Type: Physician
Filed: 5/26/2018 1:33 PM	Date of Service: 5/26/2018 7:19 AM	Creation Time: 5/26/2018 7:19 AM
Status: Signed	Editor: Raftis, James, DO (Physician)	

PATIENT: Jennifer Lyn Brown**MRN: 340616****DOB: 10/26/1976****DATE OF SERVICE: 5/26/2018****LOCATION: RPH EMERGENCY DEPARTMENT****History of Present Illness****Chief Complaint**

Patient presents with

- Abdominal Pain
- Bloating

HPI

Jennifer is a 41 yo female That presents to the emergency department complaining of abdominal pain which is been worsening over the past week. Patient has a history of Crohn's disease. She works in the GI department and she's been discussing this with her gastroenterologist. They recently did stool studies which showed negative for infection including C. Difficile. There were some inflammatory findings noted. Patient says overnight she is developed worsening right lower quadrant pain. As of this is somewhat different than her typical pain. She says movement tends to cause her more pain. He's had some nausea without vomiting.



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)**ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)**

Denies hematemesis melena or bright red blood per rectum. Patient also tells me she had a gastric sleeve surgery performed in 2014.

Patient Active Problem List**Diagnosis**

- Plantar fascial fibromatosis
- Unspecified sinusitis (chronic)
- HTN (hypertension), benign
- GERD (Gastroesophageal Reflux Disease)
- Rheumatoid arthritis (HCC)
- Hyperhidrosis disorder
- Obesity
- GAD (generalized anxiety disorder)
- Nontoxic multinodular goiter
- ADHD (attention deficit hyperactivity disorder)
- Severe obstructive sleep apnea
- Environmental allergies
- Depression
- Fibromyalgia
- Status post bariatric surgery
- Tremor of left hand
- Benign head tremor
- Crohn's disease (HCC)
- Multiple benign nevi
- Cherry angioma
- Sun-damaged skin
- Neuritis
- Drug eruption
- Rash
- Long term current use of immunosuppressive drug
- Vitamin D deficiency
- Vitamin B12 deficiency
- Therapeutic drug monitoring
- Myopia of both eyes
- Bilateral dry eyes

Past Medical History:**Diagnosis****Date**

- | | |
|-------------------------|-----------|
| • Anal fissure | 1/2013 |
| • Anxiety | |
| • Attention deficit | |
| • Back ache | 3/18/2014 |
| • Calcaneal spur | 6/30/2008 |
| • Cherry angioma | 8/9/2016 |
| • Cholecystitis | |
| • CHRONIC SINUSITIS NOS | 5/23/2005 |



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)

ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)

CT 2005		
• Crohn disease (HCC)		
• Depression		1/20/2014
• Endocrine problem		
• Epicondylitis elbow, medial		10/7/2008
• Fatty liver		
• Fibromyalgia		8/20/2014
• Fractures		
• Gastroparesis		
<i>irritable bowel syndrome</i>		
• GERD (gastroesophageal reflux disease)		10/7/2008
• HTN (hypertension), benign		10/7/2008
• Hypertension		
• Morbidly obese (HCC)		
• Multinodular goiter		
• Nontoxic multinodular goiter		1/18/2011
• Obesity		
• Persistent mental disorders due to conditions classified elsewhere		
• Physiological ovarian cysts		10/7/2008
• PLANTAR FIBROMATOSIS		9/9/2004
• Premenopausal patient		
• Rheumatoid arthritis(714.0)		12/12/2008
<i>Sees Dr. Freeman in Elmira.</i>		
• Severe obstructive sleep apnea		6/10/2013
• Sleep apnea		
• Thyroid nodule		6/3/2010
• Wrist fracture		

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
<i>Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY	N/A	6/2/2017
<i>Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD	N/A	8/13/2014
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;</i>		
• EGD	N/A	6/24/2016
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD	N/A	6/2/2017
<i>Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD (GUTHRIE / NON GUTHRIE)		
• LAPAROSCOPIC CHOLECYSTECTOMY		2013
<i>with liver biopsy</i>		
• PR CLOSED RX TARSAL FX,EACH		
• PR LAP, GAST RESTRICT PROC, LONGITUDINAL		12/10/2014



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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)

ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)

GASTRECTOMY

for obesity - Dr. Alley - RPH

- PR REMOVAL GALLBLADDER
- TONSILLECTOMY

11/26/07

Family History

Problem

Relation

Age of Onset

- | | | |
|---|----------------------|--|
| • Diabetes | Mother | |
| • Heart | Mother | |
| • Hypertension | Mother | |
| • Psychiatry | Mother | |
| <i>Anxiety</i> | | |
| • Arthritis | Mother | |
| • Heart Disease | Mother | |
| • Kidney Disease | Mother | |
| • Diabetes | Father | |
| • Hypertension | Father | |
| • Genetic | Father | |
| <i>Marfan syndrome</i> | | |
| • Heart | Father | |
| <i>?Marfan's Syndrome</i> | | |
| • Clotting Disorder | Father | |
| • Heart Disease | Father | |
| • Heart | Paternal Uncle | |
| <i>Aortic Dissection, Marfan's Syndrome</i> | | |
| • Heart Disease | Paternal Uncle | |
| • Diabetes | Maternal Grandfather | |
| • Thyroid Disease | Maternal Grandfather | |
| • Macular Degeneration | Paternal Grandmother | |
| • Psychiatry | Maternal Aunt | |
| <i>ADHD</i> | | |
| • Genetic | Maternal Aunt | |
| <i>Marfan syndrome</i> | | |
| • Psychiatry | Other | |
| <i>ADHD</i> | | |
| • Cancer | Paternal Grandfather | |
| • Glaucoma | No family history | |
| • Blindness | No family history | |
| • Other Eye Problems | No family history | |
| • Anesth Problems | No family history | |

Social History

Substance Use Topics

- | | |
|----------------------|--------------|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | Never Used |
| • Alcohol use | No |



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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)

ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)

No current facility-administered medications for this encounter.

Current Outpatient Prescriptions

Medication	Sig
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1,000 mcg within a muscle EVERY THIRTY DAYS.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit	INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
• HYDROcodone-acetaminophen (NORCO) 5-325 MG Oral Tab	Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (pain). Max Daily Amount: 6 Tabs.
• ibuprofen (MOTRIN) 800 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY.
• LEVONEST Oral Tab	TAKE ONE TABLET BY MOUTH ONCE DAILY
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Methotrexate 2.5 MG Oral Tab	Take 10 Tabs by mouth EVERY 7 DAYS.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.
• PEG-KCI-NaCI-NaSulf-Na Asc-C 100 g Oral Recon Soln	Take 100 g by mouth AS DIRECTED. Follow GI prep instructions
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.
• Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap	Take 50,000 Units by mouth EVERY 7 DAYS.

Allergies

Allergen

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Rash
Rash



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)**ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)****Review of Systems**

Negative except as noted above

Physical Exam

Temp: 96.7 °F (35.9 °C) (05/26/18 0615)

Pulse: 78 (05/26/18 0615)

Resp: 18 (05/26/18 0615)

BP: 137/89 (05/26/18 0615)

SpO2: 97 % (05/26/18 0615)

Physical Exam

General: Vital signs as noted. The patient is awake, alert and oriented to person place and time. The patient is in no distress.

HEENT: Moist mucous membranes, patent airway no sign of infection

Neck: Supple

Lungs: Clear to auscultation bilateral, no wheezes rales or rhonchi, equal breath sounds.

Heart: Regular rate and rhythm, no murmurs, rubs, or gallops.

Abdomen: Obese, soft, she does have tenderness in the right lower quadrant at McBurney's point. There is some rebound tenderness noted. No guarding. She is normoactive bowel sounds. I cannot palpate any masses.

Extremities: No clubbing cyanosis or edema

Neuro: Grossly intact. No gross deficits or asymmetries noted.

Derm: No rash.

ED Course**Procedures****Results for orders placed or performed during the hospital encounter of 05/26/18****CBC WITH DIFFERENTIAL**

Result	Value	Ref Range
WBC Count	10.2	3.6 - 11.0 K/uL
RBC Count	4.32	3.80 - 5.20 M/uL
Hemoglobin	13.6	12.0 - 16.0 g/dL
Hematocrit	39.2	35.0 - 47.0 %
MCV	90.9	80.0 - 100.0 fL



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)

ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)

MCH	31.4	26.0 - 34.0 pg
MCHC	34.5	32.0 - 36.0 g/dL
Platelet Count	257	150 - 400 K/uL
MPV	7.6	7.1 - 11.2 fL
RDW	12.7	11.0 - 15.0 %
Neutrophil %	61.5	38.0 - 70.0 %
Lymphocyte %	28.5	21.0 - 49.0 %
Monocyte %	8.1	1 - 11 %
Eosinophil %	1.3	0.0 - 7.0 %
Basophil %	0.6	0.0 - 2.0 %
Neutrophil #	6.3	1.8 - 7.7 K/uL
Lymphocyte #	2.9	1.0 - 5.0 K/uL
Monocyte #	0.8	0.0 - 0.8 K/uL
Eosinophil #	0.1	0.0 - 0.5 K/uL
Basophil #	0.1	0.0 - 0.2 K/uL

COMPREHENSIVE METABOLIC PANEL

Result	Value	Ref Range
Sodium	139	134 - 145 mmol/L
Potassium	3.8	3.5 - 5.1 mmol/L
Chloride	101	98 - 107 mmol/L
CO2	29	22 - 30 mmol/L
Calcium	8.6	8.3 - 10.1 mg/dL
Albumin	4.0	3.5 - 5.0 g/dL
BUN	15	7 - 17 mg/dL
Creatinine	0.7	0.7 - 1.2 mg/dL
Glucose	79	70 - 99 mg/dL
Total Protein	7.2	6.3 - 8.2 g/dL
Total Bilirubin	0.4	0.0 - 1.1 mg/dL
AST	26	15 - 46 U/L
ALT	41	9 - 52 U/L
Alkaline Phosphatase	48	40 - 150 U/L
eGFR	>60	See Interpretation Below ml/min/1.73m ² Sq
BUN/Creatinine Ratio	21	6 - 22
Anion Gap	9	3 - 11 mmol/L
A/G Ratio	1.3	0.8 - 2.0

LIPASE

Result	Value	Ref Range
Lipase	103	23 - 300 U/L

HCG QUALITATIVE SERUM

Result	Value	Ref Range
Hcg Qualitative Serum	Negative	Negative

C-REACTIVE PROTEIN

Result	Value	Ref Range
C-Reactive Protein	0.60	<1.00 mg/dL

SEDIMENTATION RATE

Result	Value	Ref Range
ESR	11	0 - 20 mm



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)**ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)****URINALYSIS (LAB) WITH REFLEX CULTURE**

Result	Value	Ref Range
Urine Color	Yellow	Yellow
Urine Appearance	Clear	Clear
Urine Glucose	Negative	Negative mg/dl
Urine Bilirubin	Negative	Negative
Urine Ketones	Negative	Negative
Urine Specific Gravity	1.024	1.005 - 1.030
Urine Blood	Negative	Negative
Urine Ph	6.0	5.0 - 8.0
Urine Protein	Negative	Negative mg/dl
Urine Urobilinogen	0.2	0.2 - 1.0 E.U./dL
Urine Nitrite	Negative	Negative
Urine Leukocytes	Small (A)	Negative

URINE MICROSCOPIC WITH REFLEX CULTURE

Result	Value	Ref Range
Urine Wbc	0-2	0 - 5 /HPF
Urine Epithelial Cells	Few	None Seen /HPF
Urine Bacteria	Few	None Seen /HPF
Urine Mucus	Present (A)	Negative

CT abdomen and pelvis with IV contrast:

IMPRESSION:

Fairly prominent cyst in the right ovary measuring 4.7 x 4 cm which most likely is accounting for the patient's symptoms, however, there are also mildly prominent lymph nodes in the right mid to lower abdomen with the largest measuring 8 mm in axial dimension which also could be suggestive of a mesenteric panniculitis. Clinical correlation is recommended

No definite masses, free air or free fluid seen

No evidence of inflammatory bowel disease

pelvic ultrasound:

IMPRESSION:

Large but otherwise relatively simple cyst in the right ovary measuring 3.3 x 3.3 x 4.05 cm

Free fluid is seen in the posterior cul-de-sac

These findings are unchanged from the CT scan performed earlier today



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)**ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)****Medications**

normal saline bolus 1,000 mL (0 mL Intravenous

Stopped 5/26/18 0926)

morphine syringe 4 mg (4 mg Intravenous Push

Given 5/26/18 0741)

ondansetron (ZOFTRAN) injection 4 mg (4 mg

Intravenous Push Given 5/26/18 0741)

morphine syringe 4 mg (4 mg Intravenous Push

Given 5/26/18 0929)

iohexol (OMNIPAQUE) 350 MG/ML injectable

solution 129 mL (129 mL Intravenous Push 5/26/18

0925)

ketorolac (TORADOL) injection 30 mg (30 mg

Intravenous Push Given 5/26/18 1031)

ED Course as of May 26 1332**Sat May 26, 2018**

0959 I discussed the CT and lab results with the patient. I've explained that she does have a large right ovarian cyst in all and she agrees to go forward with pelvic ultrasound for further evaluation. We also discussed pain management. She still has 5 out of 10 pain despite 8 mg of morphine IV. We'll give her one dose of Toradol IV. She tells me she's had this before and tolerated it with no problem. [JR]

ED Course User Index

[JR] Raftis, James, DO

I have reviewed this patients record on the Pennsylvania PDMP web site.

Patient Progress: stable.**Vitals:**

Temp: 96.7 °F (35.9 °C) (05/26/18 0615)

Pulse: 78 (05/26/18 0615)

Resp: 18 (05/26/18 0615)

BP: 128/77 (05/26/18 1300)

SpO2: 94 % (05/26/18 1300)

Assessment / Impression



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Notes (continued)

ED Provider Notes by Raftis, James, DO at 5/26/2018 7:19 AM (continued)

1. Right ovarian cyst
2. Right lower quadrant pain

Plan

discharge

Close observation at home

Norco if needed for pain as we discussed.

Tylenol for mild to moderate pain

Warm moist compresses

Follow-up with your GYN provider call Tuesday for an appointment

Return as needed

Electronically signed by Raftis, James, DO at 5/26/2018 1:33 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
8/16/2018 2:50 PM	Michael Fritzen	Rph Physical Therapy		RPH

Documentation Only

8/16/2018

Jennifer Lyn Brown
MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 8/16/2018 2:50 PM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 8/16/2018 2:51 PM	Encounter Date: 8/16/2018	Status: Signed
Editor: Fritzen, Michael, PT (Physical Therapist)		

We evaluated Mrs. Brown in PT on 5/25/18 and saw her 1 tx's, date last tx was 5/25/18 (see note for that date). She cancelled multiple appointments. We have not seen her in 11 weeks.



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/16/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 8/16/2018 2:50 PM (continued)**

D/c PT

Electronically signed by Fritzen, Michael, PT at 8/16/2018 2:51 PM

Patient Demographics

Name	Patient ID	SSN	Gender/Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

9/12/2018 11:00 AM	Provider	Department	Har	Center
	Michael Fritzen	Rph Physical Therapy		RPH

EVALUATION

9/12/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM**

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 9/12/2018 12:42 PM	Date of Service: 9/12/2018 11:07 AM	Creation Time: 9/12/2018 11:07 AM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic
Initial Evaluation
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Patient: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 Date of Service: 9/12/2018



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)**

Referring Physician: Michael Gorsline

Primary Diagnosis:**1. Plantar fascial fibromatosis**

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1105

Time Out: 1140

Subjective: She is a 41-y.o.-year-old female who presents for outpatient physical therapy with a chief complaint of B/L foot pain.

Started wearing flip flops a lot 3 months ago L 1st then R, + 1st step pain L

L feet fx 4 yrs ago had cast NWB

Has had R Plantar fasciitis in past had PT and wore night splint 3 yrs ago.

No pain at rest, Walking R 2/10 , L 6/10

No end of day B/L 6/10

WORSE: Standing and walking

BETTER: rest and night splint

Still having shoulder problems getting cortisone shots

Prior Functional Status: walking a lot

Current Functional Status:

not walking dog

Abuse/Neglect Screening

Are you being threatened or hurt by anyone? : No

FOTO Data

Intake FS Score: 37

Predicted FS Score: 61

Objective:**Past Medical History:**



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)

Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS CT 2005	5/23/2005
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0) Sees Dr. Freeman in Elmira.	12/12/2008
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/2/2017
Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh,		



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)

Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)

- Preetika, MD; Location: RPH MAIN OR*
- COLONOSCOPY N/A 6/11/2018
Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
 - COLONOSCOPY DIAGNOSTIC
 - EGD 2002
 - EGD N/A 8/13/2014
Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
 - EGD N/A 6/24/2016
Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
 - EGD N/A 6/2/2017
Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
 - EGD N/A 6/11/2018
Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
 - EGD (GUTHRIE / NON GUTHRIE)
 - LAPAROSCOPIC CHOLECYSTECTOMY 2013
with liver biopsy
 - PR CLOSED RX TARSAL FX,EACH
 - PR LAP, GAST RESTRICT PROC, LONGITUDINAL 12/10/2014
GASTRECTOMY
for obesity - Dr. Alley - RPH
 - PR REMOVAL GALLBLADDER
 - TONSILLECTOMY 11/26/07

Current Outpatient Prescriptions:

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 30 Cap, Rfl: 5
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses., Disp: 12 mL, Rfl: 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)**

- HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit, INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS, Disp: 4 Each, Rfl: 11
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 84 Tab, Rfl: 3
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- Methotrexate 2.5 MG Oral Tab, Take 10 Tabs by mouth EVERY 7 DAYS., Disp: 120 Tab, Rfl: 4
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- prednisONE (DELTASONE) 10 MG Oral Tab, Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop, Disp: 30 Tab, Rfl: 0
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS., Disp: 90 Cap, Rfl: 0
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 0

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Rash
Rash

ANKLE	L ROM	R ROM	L MMT	R MMT
Dorsiflex gross	5	10	5	5
Plantarflex	50	50	5	5
Adduction				
Abduction				
Eversion	10	10		
Inversion	30	30		

1st toe ROM WNL

Inspection: no callous pattern

STN Dorsiflexion: L (0), R (-5)

STN HF: B/L 6 varus

FF: B/L Flexible Plantarflexed 1st ray

Tibial Varum 0

Stance: No excessive pronation

Gait: WNL



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)****Plan of Care**

Plan of Care Start Date: 09/12/18

Plan of Care Expiration Date: 12/12/18

Prior Function Comment: walking a lot

Current Function Comment: not walking dog

Rehabilitative Prognosis: Good

Planned Intervention(s): PT Eval Low Complexity (97161); Gait Training (97116); Therapeutic Exercise (Timed) (97110); Ultrasound (Timed) (97035); Manual Therapy (Timed) (97140); Orthotic Follow Up (97763)

Frequency of Treatments: 2 times weekly

Duration of Treatments: 3 months

History Components: Moderate (1-2 personal factors and/or comorbidities)

Examination of Body Systems/Components: Low (Addressing 1-2 elements)

Clinical Presentation: Evolving - changing/inconsistent clinical characteristics (Moderate)

Clinical Decision Making (complexity): Low

Treatment Number: 1

Total Time of Evaluation: 20

Assessment: Mrs. Brown was referred to PT 2nd B/L Plantar fasciitis pain L>L. She had fx L 5th Metatarsal 4 yrs ago. She has had past hx of Plantar fasciitis that resolved. It appears her pain started 2nd to wearing flip-flops. She gets + 1st step pain. Her symptoms are consistent clinically as Plantar fasciitis. She has excessive stiffness in L ankle Dorsiflexion and her L Plantar fascia has more tautness. I instructed no barefoot walking. We will educate on 1st step pain, and soft tissue mobilization Plantar fascia, calf stretches and Laser Plnatar fascia. She might benefit from BFO offshelf orthotics we trial in future. She was thoroughly educated not to increase pain with prolonged walking. No red flag signs. Anticipated prognosis good if compliant (she never followed through with her shoulder PT).

Was Physical Therapy treatment performed at this visit?

Yes: **Interventions:**

FOTO Data



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lynn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)**

Intake FS Score: 37

Predicted FS Score: 61

Therapeutic Exercises (97110)**Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 5**

Exercise #1

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual Therapy (97140)Soft Tissue Mobilization Details: B/L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm² 2:30 and Graston #4 sweepsOther Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm² B/L plantar fascia with stretch

Total Minutes (All Manual Therapy): 15

Plan for Next Visit: Continue soft tissue and laser, review HEP, Review Education, Trial BFO's**Evaluation Complexity Assessment:** History Components: Moderate (1-2 personal factors and/or comorbidities)

Examination of Body Systems/Components: Low (Addressing 1-2 elements)

Clinical Presentation: Evolving - changing/inconsistent clinical characteristics (Moderate)

Clinical Decision Making (complexity): Low

Treatment Number: 1

Total Time of Evaluation: 20

Total Number of Timed Code Treatment Minutes: 20

Author: Michael Fritzen, PT 9/12/2018 11:57



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 9/12/2018 11:07 AM (continued)**

Electronically signed by Fritzen, Michael, PT at 9/12/2018 12:42 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

9/12/2018 11:00 AM	Provider	Department	Har	Center
	Michael Fritzen	Rph Physical Therapy		RPH

EVALUATION

9/12/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Therapy Plan of Care by Fritzen, Michael, PT at 9/12/2018 11:58 AM**

Author: Fritzen, Michael, PT	Service: ORTHOPEDIC	Author Type: Physical Therapist
Filed: 9/12/2018 12:42 PM	Date of Service: 9/12/2018 11:58 AM	Creation Time: 9/12/2018 11:58 AM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	
Cosigner: Gorsline, Michael, PA-C at 9/13/2018 8:34 AM		

The Guthrie Clinic
Initial Evaluation Plan of Care
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 Guthrie Square
Sayre PA 18840-1625
570-887-4801
570-888-6666

Patient: Jennifer Lyn Brown**MRN:** 340616**DOB:** 10/26/1976**Date of Service:** 9/12/2018**Referring Physician:** Michael Gorsline



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Therapy Plan of Care by Fritzen, Michael, PT at 9/12/2018 11:58 AM (continued)****Plan of Care Start Date:** 09/12/18**Plan of Care Expiration Date:** 12/12/18**Primary Diagnosis:****1. Plantar fascial fibromatosis**

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Prior Functional Status: walking a lot**Current Functional Status:**

not walking dog

Rehabilitative Prognosis: Good**Short Goals:** (2-4 wks)

- 1) IND education
- 2) IND 1st step pain control
- 3) decrease pain 25% end of day

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day
- 2) Intermittent pain walking
- 3) increase functional status 24 points per FOTO survey
- 4) resume walking dog pain limited

Planned Intervention(s): PT Eval Low Complexity (97161); Gait Training (97116); Therapeutic Exercise (Timed) (97110); Ultrasound (Timed) (97035); Manual Therapy (Timed) (97140); Orthotic Follow Up (97763)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: 2 times weekly**Duration of Treatment:** 3 months

The Physical Therapy Plan of Care has been discussed with the patient. Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/12/2018, D/C: 9/12/2018

Notes (continued)**Therapy Plan of Care by Fritzen, Michael, PT at 9/12/2018 11:58 AM (continued)**

my care.

Gorsline, Michael, PA-C

1 GUTHRIE SQUARE

SAYRE, PA 18840 (To be Electronically signed)

Author: Michael Fritzen, PT 9/12/2018 11:58

Electronically signed by Gorsline, Michael, PA-C at 9/13/2018 8:34 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

9/20/2018 11:00 AM	Provider	Department	Har	Center
	Berniece Abbott	Rph Physical Therapy		RPH

FOLLOW UP

9/20/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Abbott, Berniece, PTA at 9/20/2018 10:52 AM**

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 9/20/2018 11:39 AM	Date of Service: 9/20/2018 10:52 AM	Creation Time: 9/20/2018 10:52 AM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/20/2018, D/C: 9/20/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/20/2018 10:52 AM (continued)**

1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 2**Referring Physician: Michael Gorsline****Primary Diagnosis:****1. Plantar fascial fibromatosis**

ICD-9- CM	ICD-10- CM
728.71	M72.2

Time In: 1050

Time Out: 1120

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated her feet continue to be sore, let her know this condition took a long time to get and it will take a while to correct. She must do her stretches and exercises daily. Patient understood.

Interventions:**Therapeutic Exercises (97110)**

Patient Education/Home Exercise Program: Educated pateint (Educated patient on OTC inserts to wear all the time.)

Number of Exercises?: 4**Total Minutes (all Therapeutic Exercise): 15****Exercise #1****Exercise Name:** Plantarfascia stretch**Reason for Exercise:** Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)**Exercise #2****Exercise Name:** Gastroc stretch**Reason for Exercise:** Flexibility;Functional Mobility;Pain Control



Notes Report 1 4 1 9 0 7 1 3 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/20/2018, D/C: 9/20/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/20/2018 10:52 AM (continued)**

Sets/Reps: 3 X 30 Sec. each

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking (Must move feet with circles, point toes, dorsiflex)

Reason for Exercise: Flexibility; Functional Mobility; Muscle Performance; Pain Control

Location/Body Area: Bilateral; Foot; Ankle

Sets/Reps: 6 X

Resistance: None

Details: (Promotes blood flow, reduces tearing)

Exercise #4

Exercise Name: Toe lift, standing

Reason for Exercise: Strengthening; Neuromuscular Training; Pain Control

Sets/Reps: 3 X 30 sec each

Resistance: Body Weight

Details: At home perform in the shower

Manual Therapy (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 40%)

Total Minutes (All Manual Therapy): 15

Assessment: Patient demonstrates understanding of the importance of stretching, OTC orthotics, icing, movement before ambulating. Patient is motivated to work on this due to the pain that has been reduced since her SOC. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue to reduce Soft tissue restriction in her calves and feet. Continue strengthening the plantar area of her feet.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 30****Total Treatment Minutes: 30**

Author: Berniece Abbott, PTA 9/20/2018 11:33

Electronically signed by Abbott, Berniece, PTA at 9/20/2018 11:39 AM

Patient Demographics



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/25/2018, D/C: 9/25/2018

Notes (continued)

Patient Demographics (continued)

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

9/25/2018 12:00 PM	Provider Berniece Abbott	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP

9/25/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Abbott, Berniece, PTA at 9/25/2018 1:06 PM

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 9/25/2018 1:17 PM	Date of Service: 9/25/2018 1:06 PM	Creation Time: 9/25/2018 1:06 PM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 3

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9- CM	ICD-10- CM
728.71	M72.2



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/25/2018, D/C: 9/25/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/25/2018 1:06 PM (continued)**

Time In: 1206

Time Out: 1310

Total Session Minutes: 64

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated she feels the stretches and manual is working on reducing her pain. She will get inserts for her shoes on pay day.

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 15****Exercise #1**

Exercise Name: Plantar fascia stretch

Reason for Exercise: Flexibility; Functional Mobility; Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility; Functional Mobility; Pain Control

Location/Body Area: Bilateral; Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking (Must move feet with circles, point toes, dorsiflex)

Reason for Exercise: Flexibility; Functional Mobility; Muscle Performance; Pain Control

Location/Body Area: Bilateral; Foot; Ankle

Sets/Reps: 6 X

Resistance: None

Details: (Promotes blood flow, reduces tearing)

Exercise #4



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/25/2018, D/C: 9/25/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/25/2018 1:06 PM (continued)**

Exercise Name: Toe lift, standing

Reason for Exercise: Strengthening; Neuromuscular Training; Pain Control

Sets/Reps: 3 X 30 sec each

Resistance: Body Weight

Details: At home perform in the shower

Manual Therapy (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 40%)

Total Minutes (All Manual Therapy): 15

Assessment: Patient demonstrates reduced pain throughout her day and continues to roll feet on ice at night. Patient is compliant with HEP. Patient is improving, and will continue to stretch and strengthen for pain free status. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue to work with soft tissue restriction in the plantar fascia to improve function.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 30****Total Treatment Minutes: 30**

Author: Berniece Abbott, PTA 9/25/2018 13:10

Electronically signed by Abbott, Berniece, PTA at 9/25/2018 1:17 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
9/25/2018 12:00 PM	Berniece Abbott	Rph Physical Therapy		RPH



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/25/2018, D/C: 9/25/2018

Notes (continued)

Contact Information (continued)

FOLLOW UP

9/25/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Abbott, Berniece, PTA at 9/25/2018 11:59 PM

Author: Abbott, Berniece, PTA

Service: —

Author Type: Physical Therapy
Assistant

Filed: 9/27/2018 4:10 PM

Date of Service: 9/25/2018 11:59 PM Creation Time: 9/27/2018 4:03 PM

Status: Signed

Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

While doing my last note on 9/25/18, patient: Jennifer Lyn Brown, I noted I had made a mistake on the Time billed on the patient. The total time of this session should have been 34 minutes and not 64 minutes.

09/27/18

Berniece Abbott, PTA

16:04

Electronically signed by Abbott, Berniece, PTA at 9/27/2018 4:10 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

Generated on 7/3/19 12:55 PM

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Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/27/2018, D/C: 9/27/2018

Notes (continued)

Contact Information (continued)

	Provider	Department	Har	Center
9/27/2018 10:30 AM	Berniece Abbott	Rph Physical Therapy		RPH

FOLLOW UP

9/27/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Abbott, Berniece, PTA at 9/27/2018 3:49 PM

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 9/27/2018 4:12 PM	Date of Service: 9/27/2018 3:49 PM	Creation Time: 9/27/2018 3:49 PM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 4

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1035

Time Out: 1105

Total Session Minutes: 30

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient reports doing well. Pain reduction, only flares when she is on her

Generated on 7/3/19 12:55 PM

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Notes Report 1 4 1 9 0 7 1 3 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/27/2018, D/C: 9/27/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/27/2018 3:49 PM (continued)**

feet a lot. Patient stated she will get OTC orthotics this weekend.

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 10****Exercise #1****Exercise Name:** Plantar fascia stretch**Reason for Exercise:** Flexibility; Functional Mobility; Pain Control (Reduce stress on fascia)**Sets/Reps:** 3X30" ea**Details:** Bilateral feet**Exercise #2****Exercise Name:** Gastroc stretch**Reason for Exercise:** Flexibility; Functional Mobility; Pain Control**Location/Body Area:** Bilateral; Foot**Sets/Reps:** 3 X 30 Sec. each**Details:** hands on wall**Exercise #4****Exercise Name:** Toe lift, standing**Reason for Exercise:** Strengthening; Neuromuscular Training; Pain Control**Sets/Reps:** 3 X 30 sec each**Resistance:** Body Weight**Details:** At home perform in the shower**Manual Therapy (97140)****Soft Tissue Mobilization:** Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)**Soft Tissue Mobilization Details:** B/L plantar fascia**Instrument-Assisted Soft Tissue Mobilization:** IASTM (IASTM on B/L calves and plantar fascia)**IASTM Details:** B/L calves and feet (Reduced STR 40%)**Total Minutes (All Manual Therapy):** 20

Assessment: Patient demonstrates Compliance with HEP and has reduction in daily pain levels. If patient continues and gets OTC orthotic she may be ready for D/C. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue with strengthening LE.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes:** 30**Total Treatment Minutes:** 30



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/27/2018, D/C: 9/27/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 9/27/2018 3:49 PM (continued)**

Author: Berniece Abbott, PTA 9/27/2018 15:59

Electronically signed by Abbott, Berniece, PTA at 9/27/2018 4:12 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

10/3/2018 12:30 PM	Provider	Department	Har	Center
	Berniece Abbott	Rph Physical Therapy		RPH

FOLLOW UP

10/3/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Abbott, Berniece, PTA at 10/3/2018 12:43 PM**

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 10/3/2018 2:40 PM	Date of Service: 10/3/2018 12:43 PM	Creation Time: 10/3/2018 12:43 PM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
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 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 5**Referring Physician: Michael Gorsline**



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/3/2018, D/C: 10/3/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/3/2018 12:43 PM (continued)****Primary Diagnosis:**

	ICD-9- CM	ICD-10- CM
1. Plantar fascial fibromatosis	728.71	M72.2

Time In: 1230

Time Out: 1302

Total Session Minutes: 32

Pain at Start of Care: 2/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated she will be getting her orthotics this weekend. She will have 5 days off. Patient stated her feet have been sore, but not painful

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 3****Total Minutes (all Therapeutic Exercise): 10****Exercise #1**

Exercise Name: Plantarfascia stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea

Details: Bilateral feet

Exercise #2

Exercise Name: Gastroc stretch

Reason for Exercise: Flexibility;Functional Mobility;Pain Control

Location/Body Area: Bilateral;Foot

Sets/Reps: 3 X 30 Sec. each

Details: hands on wall

Exercise #3

Exercise Name: Heel/Toe raises

Reason for Exercise: Flexibility;Strengthening;Muscle Performance

Location/Body Area: Bilateral;Foot

Sets/Reps: (x 30)



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/3/2018, D/C: 10/3/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/3/2018 12:43 PM (continued)**

Resistance: none

Manual Therapy (97140)

Soft Tissue Mobilization: Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)

Soft Tissue Mobilization Details: B/L plantar fascia

Instrument-Assisted Soft Tissue Mobilization: IASTM (IASTM on B/L calves and plantar fascia)

IASTM Details: B/L calves and feet (Reduced STR 20%)

Total Minutes (All Manual Therapy): 20

Assessment: Patient demonstrates continued improvement with less pain in her feel and able to be on them more. Patient states she is compliant with her HEP. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue to strengthen and stretch involved musculatures.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 30

Total Treatment Minutes: 30

Author: Berniece Abbott, PTA 10/3/2018 14:37

Electronically signed by Abbott, Berniece, PTA at 10/3/2018 2:40 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
10/11/2018 11:00 AM	Berniece Abbott	Rph Physical Therapy		RPH

FOLLOW UP

10/11/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Abbott, Berniece, PTA at 10/11/2018 11:15 AM**



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/11/2018, D/C: 10/11/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/11/2018 11:15 AM (continued)**

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 10/11/2018 12:18 PM	Date of Service: 10/11/2018 11:15 AM	Creation Time: 10/11/2018 11:15 AM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 6**Referring Physician:** Michael Gorsline**Primary Diagnosis:****1. Plantar fascial fibromatosis**

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1110

Time Out: 1133

Total Session Minutes: 23

Pain at Start of Care: 4/10

Pain at End of Care: 2/10

Subjective Comments: Patient went on a vacation to the Pocono's and did a lot of walking, increasing the pain in her feet. She continues to be compliant with her HEP, except on her vacation.

Interventions:

Exercise #1

Exercise Name: Plantar fascia stretch

Reason for Exercise: Flexibility; Functional Mobility; Pain Control (Reduce stress on fascia)

Sets/Reps: 3X30" ea



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/11/2018, D/C: 10/11/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/11/2018 11:15 AM (continued)****Details: Bilateral feet****Exercise #2****Exercise Name:** Gastroc stretch**Reason for Exercise:** Flexibility; Functional Mobility; Pain Control**Location/Body Area:** Bilateral; Foot**Sets/Reps:** 3 X 30 Sec. each**Details:** hands on wall**Exercise #3****Exercise Name:** Heel/Toe raises**Reason for Exercise:** Flexibility; Strengthening; Muscle Performance**Location/Body Area:** Bilateral; Foot**Sets/Reps:** (x 30)**Resistance:** none**Manual Therapy (97140)****Soft Tissue Mobilization:** Manual Tissue Mobilization (DTM, on plantar fascia, post calf bilaterally)**Soft Tissue Mobilization Details:** B/L plantar fascia**Instrument-Assisted Soft Tissue Mobilization:** IASTM (IASTM on B/L calves and plantar fascia)**IASTM Details:** B/L calves and feet (Reduced STR 20%)**Total Minutes (All Manual Therapy):** 15

Assessment: Patient having increased pain in her plantar fascia. She went on vacation walked a lot however did not do her daily stretches and ice her feet. Patient did start her HEP as soon as she returned. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue to work on plantar fascia, adding ultra sound for healing properties.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes:** 23**Total Treatment Minutes:** 23**Author:** Berniece Abbott, PTA 10/11/2018 12:13

Electronically signed by Abbott, Berniece, PTA at 10/11/2018 12:18 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/15/2018, D/C: 10/15/2018

Notes (continued)

Patient Demographics (continued)

14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES
Reg Status Verified	PCP Gillan, Michael F, DO570-887-2239		

Contact Information

10/15/2018 12:00 PM	Provider Michael Fritzen	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP

10/15/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 10/15/2018 12:04 PM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 10/15/2018 12:39 PM	Date of Service: 10/15/2018 12:04 PM	Creation Time: 10/15/2018 12:04 PM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic

Progress Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 Guthrie Square

Sayre PA 18840-1625

570-887-4801

570-888-6666

Treatment Number: 7

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9- CM	ICD-10- CM
728.71	M72.2

Time In: 1200



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/15/2018, D/C: 10/15/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 10/15/2018 12:04 PM (continued)**

Time Out: 1230

Total Session Minutes: 30

Pain at Start of Care: 0/10

Walking 3/10

Pain at End of Care: 0/10

Subjective Comments: Last night pain 3/10

1st step pain better

Not barefoot walking

Has not got orthotic

Calf 2-3/day

Ice bottle PRN

L foot pain worse than R

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 15**

Exercise #1

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4

Exercise Name: Trialled BFO 5 orthotics > felt much better



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/15/2018, D/C: 10/15/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 10/15/2018 12:04 PM (continued)****Manual Therapy (97140)**

Soft Tissue Mobilization Details: B/L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm² 2:30 and Graston #4 sweeps

PROM: Plantar fascia stretches

Joint Mobilization: Posterior Talar glides B/L

Other Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm² B/L plantar fascia with stretch

Total Minutes (All Manual Therapy): 15

Assessment: We evaluated Mrs. Brown in PT on 9/12/18 and have seen her 7 tx's, 2nd to B/L Plantar fasciitis. She has been compliant with her PT services and is slowly progressing better. I feel she needs basic offshelf arch support BFO 5, to help decrease stress across plantar fascia 2nd to her wt. She will get today. Reviewed pt education she is IND with 1st step, and not increasing pain with walking program. Recommend her to perform ex bike for wt loss. Continue to see 1-2/wk until pain better than 1/1-2 wks till she is walking pain free.

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- PROGRESSING
- 2) Intermittent pain walking
- 3) increase functional status 24 points per FOTO survey -- PROGRESSING
- 4) resume walking dog pain limited

Plan for Next Visit: Continue soft tissue

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 30

Total Treatment Minutes: 30

Author: Michael Fritzen, PT 10/15/2018 12:36

Electronically signed by Fritzen, Michael, PT at 10/15/2018 12:39 PM



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/17/2018, D/C: 10/17/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

10/17/2018 1:00 PM	Provider Berniece Abbott	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP
10/17/2018Jennifer Lyn Brown
MRN: 340616**Notes****Progress Notes by Abbott, Berniece, PTA at 10/17/2018 1:28 PM**

Author: Abbott, Berniece, PTA	Service: —	Author Type: Physical Therapy Assistant
Filed: 10/17/2018 2:18 PM	Date of Service: 10/17/2018 1:28 PM	Creation Time: 10/17/2018 1:28 PM
Status: Signed	Editor: Abbott, Berniece, PTA (Physical Therapy Assistant)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 8**Referring Physician: Michael Gorsline****Primary Diagnosis:**

1. Plantar fascial fibromatosis

ICD-9- CM	ICD-10- CM
728.71	M72.2



GUTHRIE

Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/17/2018, D/C: 10/17/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/17/2018 1:28 PM (continued)**

Time In: 1315

Time Out: 1345

Total Session Minutes: 30

Pain at Start of Care: 0/10

Pain at End of Care: 0/10

Subjective Comments: Patient stated doing better.**Interventions:****Cardiovascular Exercise (97110)****Number of Cardiovascular Exercise(s): 1****Time (minutes): 5**

Cardiovascular Exercise 1

Equipment Used: Recumbent Bike

Purpose of Exercise: Functional Mobility

Intensity: (level 4)

Therapeutic Exercises (97110)**Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 10**

Exercise #1

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: Band Walking

Reason for Exercise: Functional Mobility; Muscle Performance

Location/Body Area: Bilateral; LE

Sets/Reps: 3 ways 20'

Resistance: Red band

Exercise #4

Exercise Name: Toe Raises

Reason for Exercise: Functional Mobility; Muscle Performance

Location/Body Area: Bilateral; LE

Sets/Reps: X 30



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/17/2018, D/C: 10/17/2018

Notes (continued)**Progress Notes by Abbott, Berniece, PTA at 10/17/2018 1:28 PM (continued)****Manual Therapy (97140)**

Soft Tissue Mobilization: Manual Tissue Mobilization;IASTM

Instrument-Assisted Soft Tissue Mobilization: (Empahsis on left heel)

PROM: Plantarfascia stretches

Total Minutes (All Manual Therapy): 15

Comment:

Patient purchased BFO 5 orthotics

(Helped patientso they fit better, took out her insole's.)

Assessment: Patient demonstrates Improvement with the purchase of the BFO 5 orthotics. Patient also reports being able to stand longer and walk further. Still having some problems when first standing, however working on this. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments.

Plan for Next Visit: Continue to strengthen patient's plantar fascia with increased strengthening.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 30****Total Treatment Minutes: 30**

Author: Berniece Abbott, PTA 10/17/2018 14:12

Electronically signed by Abbott, Berniece, PTA at 10/17/2018 2:18 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
10/24/2018 11:30 AM	Michael Fritzen	Rph Physical Therapy		RPH



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/24/2018, D/C: 10/24/2018

Notes (continued)

FOLLOW UP
 10/24/2018

Jennifer Lyn Brown
 MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 10/24/2018 11:38 AM

 Author: Fritzen, Michael, PT
 Filed: 10/24/2018 12:03 PM

 Service: —
 Date of Service: 10/24/2018 11:38 AM

 Author Type: Physical Therapist
 Creation Time: 10/24/2018 11:38 AM

Status: Signed

Editor: Fritzen, Michael, PT (Physical Therapist)

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 9

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1135

Time Out: 1200

Total Session Minutes: 25

 Pain at Start of Care: 1/10
 Walking 3/10 L foot

Pain at End of Care: 1/10

Subjective Comments: IND 1st step pain education < no pain

Wall stretch 3/day

R foot feels 100% better

Drug induced Lupus > seeing Rheumatology today

Generated on 7/3/19 12:55 PM



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/24/2018, D/C: 10/24/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 10/24/2018 11:38 AM (continued)****Interventions:**

Educated on activity and pain, And ex bike for wt loss (can use guthrie gym)

Therapeutic Exercises (97110)**Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 10****Exercise #1**

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual Therapy (97140)

Soft Tissue Mobilization Details: L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm2 5:00 and Graston #4 sweeps

PROM: Plantar fascia stretches

Other Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm2 L plantar fascia with stretch

Total Minutes (All Manual Therapy): 15

Assessment: Patient demonstrates better progress with pain. Her R foot 100% better, L progressing. She is IND with Pt education. Continue soft tissue > if better next tx then can decrease to 1/1-2 wks. Can use ex bike for wt loss until painfree then can restart walking program.

Plan for Next Visit: See above**Total UNTIMED Code Treatment Minutes:****Total TIMED Code Treatment Minutes: 25****Total Treatment Minutes: 25**



Notes Report

1 4 1 9 0 7 1 2 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/24/2018, D/C: 10/24/2018

Notes (continued)

Progress Notes by Fritzen, Michael, PT at 10/24/2018 11:38 AM (continued)

Author: Michael Fritzen, PT 10/24/2018 12:01

Electronically signed by Fritzen, Michael, PT at 10/24/2018 12:03 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

10/26/2018 11:30 AM	Provider	Department	Har	Center
	Michael Fritzen	Rph Physical Therapy		RPH

FOLLOW UP

10/26/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 10/26/2018 11:35 AM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 10/26/2018 12:01 PM	Date of Service: 10/26/2018 11:35 AM	Creation Time: 10/26/2018 11:35 AM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 10

Referring Physician: Michael Gorsline



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/26/2018, D/C: 10/26/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 10/26/2018 11:35 AM (continued)****Primary Diagnosis:****1. Plantar fascial fibromatosis**

ICD-9- CM	ICD-10- CM
728.71	M72.2

Time In: 1134

Time Out: 1153

Total Session Minutes: 19

Pain at Start of Care: 0/10
Walk 2/10

Pain at End of Care: 0/10

Subjective Comments: 1st step pain better
Overall better, No pain R 100% better

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 4****Total Minutes (all Therapeutic Exercise): 5****Exercise #1**

Exercise Name: Plantar fascia stretch

Details: cued to bring meta head P-A also

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Manual Therapy (97140)



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/26/2018, D/C: 10/26/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 10/26/2018 11:35 AM (continued)**

Soft Tissue Mobilization Details: L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm2 5:00 and Graston #4 sweeps

PROM: Plantar fascia stretches

Other Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm2 L plantar fascia with stretch

Total Minutes (All Manual Therapy): 15

Assessment: Patient demonstrates better progress > L foot pain decreasing with walking. She is IND with pt education and HEP. Patient also reports ongoing difficulty in Pain walking. See next wk continue soft tissue > if better than decrease to 1/2 wks.

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- PROGRESSING
- 4) resume walking dog pain limited

Plan for Next Visit: See POC

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 20

Total Treatment Minutes: 20

Author: Michael Fritzen, PT 10/26/2018 11:53

Electronically signed by Fritzen, Michael, PT at 10/26/2018 12:01 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/2/2018, D/C: 11/2/2018

Notes (continued)

Patient Demographics (continued)

Address	Phone	Email	Employer
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES
Reg Status	PCP		
Verified	Gillan, Michael F, DO570-887-2239		

Contact Information

11/2/2018 10:30 AM	Provider Michael Fritzen	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP

11/2/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 11/2/2018 10:39 AM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 11/2/2018 10:58 AM	Date of Service: 11/2/2018 10:39 AM	Creation Time: 11/2/2018 10:39 AM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 570-887-4801
 570-888-6666

Treatment Number: 11

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1035



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/2/2018, D/C: 11/2/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 11/2/2018 10:39 AM (continued)**

Time Out: 1058

Total Session Minutes: 23

Pain at Start of Care: 0/10

Walking 1/10

Pain at End of Care: 0/10

Subjective Comments:

Got new shoes

1st step better, No barefoot

Interventions:**Therapeutic Exercises (97110)****Total Minutes (all Therapeutic Exercise): 8****Manual Therapy (97140)**

Soft Tissue Mobilization Details: L Plantarfascia: US 1.0 MHZ continuous 1.2 watt/cm2 5:00 and

Graston #4 sweeps

PROM: Plantarfascia stretches

Other Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm2 L plantarfascia with stretch

Total Minutes (All Manual Therapy): 15

Assessment: Patient demonstrates good progress pain intermittent and only 1/10 walking. She is IND with pt education and HEP. Discussed tx plan see in 2 wks. Patient also reports ongoing difficulty in pain walking.

Plan for Next Visit: reassess**Total UNTIMED Code Treatment Minutes:****Total TIMED Code Treatment Minutes: 23****Total Treatment Minutes: 23**

Author: Michael Fritzen, PT 11/2/2018 10:57



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/2/2018, D/C: 11/2/2018

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 11/2/2018 10:39 AM (continued)**

Electronically signed by Fritzen, Michael, PT at 11/2/2018 10:58 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

11/2/2018 1:15 PM	Provider	Department	Har	Center
	RPH NEURODIAGNOSTI C, KOH	Rph Neurodiagnostics Lab		RPH

EMG

11/2/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Thomas, Lura at 11/2/2018 1:36 PM**

Author: Thomas, Lura	Service: —	Author Type: Therapist
Filed: 11/2/2018 1:36 PM	Date of Service: 11/2/2018 1:36 PM	Creation Time: 11/2/2018 1:36 PM
Status: Signed	Editor: Thomas, Lura (Therapist)	

RPH Neurodiagnostics Lab
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-4635

Patient: Jennifer Lyn Brown

MRN: 340616

Sex: female

Date of birth: 10/26/1976

Handedness: Right

Diabetic: Patient is not diabetic

Date of test: 11/2/2018



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/2/2018, D/C: 11/2/2018

Notes (continued)**Progress Notes by Thomas, Lura at 11/2/2018 1:36 PM (continued)****Technologist's Notes:**

Technician: Lura Thomas

Electronically signed by Thomas, Lura at 11/2/2018 1:36 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
11/16/2018 2:07 PM	Michael Fritzen	Rph Physical Therapy		RPH

Documentation Only

11/16/2018

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Fritzen, Michael, PT at 11/16/2018 2:07 PM**

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 11/16/2018 2:08 PM	Encounter Date: 11/16/2018	Status: Signed
Editor: Fritzen, Michael, PT (Physical Therapist)		

Did not show for PT appointment I called and left message

Electronically signed by Fritzen, Michael, PT at 11/16/2018 2:08 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)

Patient Demographics (continued)

Reg Status	PCP
Verified	Gillan, Michael F, DO570-887-2239

Contact Information

1/7/2019 4:30 PM	Provider Michael Fritzen	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP

1/7/2019

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 1/7/2019 4:33 PM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 1/7/2019 5:20 PM	Date of Service: 1/7/2019 4:33 PM	Creation Time: 1/7/2019 4:33 PM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic
REASSESSMENT Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Treatment Number: 12

Referring Physician: Michael Gorsline

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1632

Time Out: 1700

Total Session Minutes: 28

Pain at Start of Care: 3/10

Generated on 7/3/19 12:55 PM



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 1/7/2019 4:33 PM (continued)**

Walking 3/10

Pain at End of Care: 1/10

Subjective Comments:

Her dad passed away > been very busy helping to care for mom and stressful

Foot still hurting in mid foot

Night pain beginning of night

1st step pain better

Interventions:**Therapeutic Exercises (97110)****Number of Exercises?: 5****Total Minutes (all Therapeutic Exercise): 13**

Exercise #1

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4

Exercise Name: Educated shoe styles

Manual Therapy (97140)Soft Tissue Mobilization Details: L Plantar fascia: US 1.0 MHZ continuous 1.2 watt/cm² 5:00 and Graston #4 sweeps

PROM: Plantar fascia stretches

Joint Mobilization: L: Posterior Talar glides, Talo-cural distraction

Other Manual Therapy Treatment Performed: Laser infrared/red 6 J/cm² L plantar fascia with stretch

Total Minutes (All Manual Therapy): 15



Notes Report

1 41 907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 1/7/2019 4:33 PM (continued)**

Assessment: We evaluated Mrs. Brown in PT 9/12/18 and have seen her 12 tx, 2nd to L Plantar fascitis. She was doing well, but recently her pain returned some 2nd to father dying and her not doing HEP as much. She is wearing minimalist style shoe and this has no intrinsic stability > I would recommend a Neutral shoe. She also needs to perform a wt loss program > this will help to decrease amount of force impact. If pain not better than she might benefit from custom orthotics > we will continue to follow 1/ 2wks. Her ROM is good and she doe not have any excessive pronation noted. Patient also reports ongoing difficulty in walking.

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- PROGRESSING
- 4) resume walking dog pain limited -- Not Met

Plan for Next Visit: See above**Total UNTIMED Code Treatment Minutes:****Total TIMED Code Treatment Minutes:** 28**Total Treatment Minutes:** 28

Author: Michael Fritzen, PT 1/7/2019 17:14

Electronically signed by Fritzen, Michael, PT at 1/7/2019 5:20 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT	607-215-0584 (H)	jenlyn9598@yahoo.c	GUTHRIE MEDICAL	
429	607-483-1886 (M)	om	GROUP	
WELLSBURG NY			EMPLOYEES	
14894				



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)

Patient Demographics (continued)

Reg Status	PCP
Verified	Gillan, Michael F, DO570-887-2239

Contact Information

1/7/2019 4:30 PM	Provider Michael Fritzen	Department Rph Physical Therapy	Har	Center RPH
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FOLLOW UP

1/7/2019

Jennifer Lyn Brown

MRN: 340616

Notes

Therapy Plan of Care by Fritzen, Michael, PT at 1/7/2019 5:18 PM

Author: Fritzen, Michael, PT	Service: ORTHOPEDIC	Author Type: Physical Therapist
Filed: 1/7/2019 5:20 PM	Date of Service: 1/7/2019 5:18 PM	Creation Time: 1/7/2019 5:18 PM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	
Cosigner: Gorsline, Michael, PA-C at 1/8/2019 10:28 AM		

The Guthrie Clinic
Re-Evaluation Plan of Care
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 1/7/2019

Referring Physician: Michael Gorsline

Plan of Care Start Date: 01/07/19

Plan of Care Expiration Date: 04/07/19

Primary Diagnosis:

1. Plantar fascial fibromatosis

ICD-9-	ICD-10-
CM	CM
728.71	M72.2



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)**Therapy Plan of Care by Fritzen, Michael, PT at 1/7/2019 5:18 PM (continued)****Prior Functional Status:** walking a lot**Current Functional Status:**

not walking dog

Rehabilitative Prognosis: Good**Goals:****Short Goals:** (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- PROGRESSING
- 4) resume walking dog pain limited -- NOT MET

Planned Intervention(s): Gait Training (97116);Therapeutic Activity (Timed) (97530);Therapeutic Exercise (Timed) (97110);Ultrasound (Timed) (97035);Manual Therapy (Timed) (97140);Ortho (Fit) Training (Timed) (97760);Orthotic Follow Up (97763);Self Care Instructions (Timed) (97535)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: Other (see Comment)(1/1-3 wks)**Duration of Treatment:** 3 months

The Physical Therapy Plan of Care has been discussed with the patient . Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under my care.

Gorsline, Michael, PA-C

1 GUTHRIE SQUARE

SAYRE, PA 18840 (To be Electronically signed)

Author: Michael Fritzen, PT 1/7/2019 17:20



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

Notes (continued)

Therapy Plan of Care by Fritzen, Michael, PT at 1/7/2019 5:18 PM (continued)

Electronically signed by Gorsline, Michael, PA-C at 1/8/2019 10:28 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

2/1/2019 12:00 PM	Provider	Department	Har	Center
	Michael Fritzen	Rph Physical Therapy		RPH

FOLLOW UP

2/1/2019

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Fritzen, Michael, PT at 2/1/2019 12:05 PM

Author: Fritzen, Michael, PT	Service: —	Author Type: Physical Therapist
Filed: 2/1/2019 12:25 PM	Date of Service: 2/1/2019 12:05 PM	Creation Time: 2/1/2019 12:05 PM
Status: Signed	Editor: Fritzen, Michael, PT (Physical Therapist)	

The Guthrie Clinic
DISCHARGE Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Treatment Number: 13

Referring Physician: Michael Gorsline



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/1/2019, D/C: 2/1/2019

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 2/1/2019 12:05 PM (continued)****Primary Diagnosis:****1. Plantar fascial fibromatosis**

ICD-9-	ICD-10-
CM	CM
728.71	M72.2

Time In: 1204

Time Out: 1220

Total Session Minutes: 16

Pain at Start of Care: 0/10

Pain at End of Care: 0/10

Subjective Comments:

Walking pain 0/10

Feels 95% better

Interventions:**Exercise #1**

Exercise Name: Plantar fascia stretch

Exercise #2

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4

Exercise Name: Educated healthy eating and wt loss activity 150 minutes/wk of endurance and strength training

Details: understood

Normal gait pattern pain free

Assessment: We evaluated Mrs. Brown in PT 9/12/18 and have seen her



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
 Brown, Jennifer Lyn
 MRN: 340616, DOB: 10/26/1976, Sex: F
 Adm: 2/1/2019, D/C: 2/1/2019

Notes (continued)**Progress Notes by Fritzen, Michael, PT at 2/1/2019 12:05 PM (continued)**

13 tx, 2nd to L Plantar fascitis. Today she feels 95% better, and does not have any pain walking since she restarted HEP. She is IND with pt education and HEP for foot. We also educated on wt loss: healthy eating and activity plan. All goals met, she feels able to self manage > therefore we will d/c her PT services.

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- MET
- 4) resume walking dog pain limited -- MET

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 16****Total Treatment Minutes: 16**

Author: Michael Fritzen, PT 2/1/2019 12:24

Electronically signed by Fritzen, Michael, PT at 2/1/2019 12:25 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

Generated on 7/3/19 12:55 PM

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Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Contact Information (continued)

	Provider	Department	Har	Center
3/22/2019 8:30 PM	Rph Sleep Lab	Rph Sleep Lab		RPH

SLEEP STUDY TEST

3/22/2019

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM

Author: Merrill, Joan, RRT

Filed: 3/23/2019 6:30 AM

Status: Signed

Service: —

Date of Service: 3/22/2019 11:59 PM

Editor: Merrill, Joan, RRT (Respiratory Therapist)

Author Type: Respiratory Therapist

Creation Time: 3/23/2019 12:26 AM

Guthrie Sleep Disorders Center
RPH Sleep Lab
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-4639

Patient: Jennifer Lyn Brown

MRN: 340616

Date of birth: 10/26/1976

Study Type: NPSG

Date of test: 3/22/2019

Technician: Joan Merrill, RRT

Room #: 1

Acq #: 01001288

Pre-Testing Questionnaire

- 1) What time did you fall asleep last night? 10 pm
- 2) What time did you wake up this morning? 540 am
- 3) Was this a typical night's sleep for you? yes
If no, please explain:
- 4) Approximately how many hours did you sleep...
Last night 6.5
Two nights ago 7
Three nights ago 7
- 5) How many naps did you have today? none
How long?
- 6) How tired/sleepy are you now? (Wide awake = 1, Can't keep my eyes open = 10) 6
- 7) Has anything out of the ordinary happened to you recently? yes Please explain Lost my dad 12/4/2018 and my grandma 2/7/19-under a lot of stress
- 8) Do you take medications to help you sleep? no Please list:



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

9) Have you taken any prescription or over the counter medications today? yes Please list:

See below

10) Do any occurrences during sleep concern you? Just wake up tired.

11) Do you have any medical problems or sleep habits that the technician should be made aware? none

12) Did you consume any alcohol today? no

13) Did you consume any caffeine today? yes

14) Current vitals: Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m²

Technician Summary

Current medications:

Current Outpatient Medications

Medication	Sig
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap	Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does	25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)**Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)**

- not apply Misc
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications**Medication**

- saline (OCEAN) nasal spray 0.65 %



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

Technician Pretest Summary

Ms. Brown arrived on time for her sleep study. She is a very pleasant 42 year old. Her PMH includes: hypertension, rheumatoid arthritis, gastroparesis, GERD, anxiety, depression, fibromyalgia, attention deficit, back ache, chronic sinusitis, multinodular goiter and a previous diagnosis of OSA in 2013.

The patient had gastric sleeve surgery and quit using her CPAP after weight loss. She has been feeling more and more fatigued and thinks maybe she still needs the CPAP but no longer has the machine. She has regained some weight since then.

The patient has a history of severe daytime sleepiness and difficulty falling/staying asleep. She clenches her jaw when sleeping. She was knocked unconscious in 1998 when she suffered a head injury.

The patient is aware of severe snoring. Her

Epworth Score is 4. The patient becomes drowsy when riding as a passenger for more than an hour or lying down to rest in the afternoon when circumstances permit. She typically does not nap. She is unaware of any apnea/abnormal breathing.

The patient typically awakens unrefreshed. She typically consumes 2 caffeinated beverages a day.

The patient has not been using any therapy at home. Sleep apnea and CPAP discussed with the patient. She was setup according to policy and procedure.

Time	Epoch	Stage	Position	SaO2	Modality
2236	112	Wake	Supine	97	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
		Respiratory rate 18		86	Calibrations begun

Additional comments: 2234 LIGHTS OUT

Time	Epoch	Stage	Position	SaO2	Modality
2306	172	Wake/1/2	Supine/right	96	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	None	No snoring	92	Tachycardia

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
2336	232	2/3	Right	96	N/A



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible RERAS	Moderate snoring	101	Tachycardia

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0006	292	3/2	Right	96	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	None	Occasional moderate snoring	97	Tachycardia

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0036	352	2/3/2/3	Right	96	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Hypopneas	Occasional moderate snoring	100	Tachycardia

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0106	412	3/2	Right	96	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	RERAs	Light snoring	94	Tachycardia

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0136	472	2	Right/supine	91	N/A



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Hypopneas and RERAs	Light snoring	88	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0206	532	2/3	Supine	90	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Hypopneas and RERAs	Moderate to heavy snoring	89	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0236	592	3/2	Supine	95	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Hypopneas and RERAs	Occasional heavy snoring	84	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0306	652	2/REM	Supine	93	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Hypopneas, RERAs and Mixed apnea	Occasional heavy snoring	77	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0336	712	2	Supine/right	96	N/A



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	RERAs	Moderate to heavy snoring	80	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0406	772	2	Right	96	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	few	None	Light snoring	84	Leg movements

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0436	832	2/REM	Right	98	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	RERAs	Light snoring	81	Leg movements

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
0506	892	2	Right	95	N/A
	Arousals	Respiratory Events	Snoring	HR	Comments
	few	Couple RERAs	Moderate snoring	79	

Additional comments: 0529 LIGHTS ON. Calibrations

Supplemental O2 Setting: No oxygen used

Tolerance: Very well

Humidifier: heated

Generated on 7/3/19 12:55 PM



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/22/2019, D/C: 3/22/2019

Notes (continued)

Progress Notes by Merrill, Joan, RRT at 3/22/2019 11:59 PM (continued)

C-Flex:

Chin Strap:

Lights on: 0529

Lights off: 2244

Bathroom visits: 0

Bed elevation: Flat

Number of pillows: 1

Post-Testing Questionnaire

- 1) How long did it take you to fall asleep last night? hrs 30 min
 - 2) How many times did you wake up last night? 2
 - 3) How tired/sleepy are you now? (can't keep my eyes open = 1, wide awake = 5) 4
 - 4) Was the bed comfortable? (not at all = 1, very = 5) 5
 - 5) Was the temperature comfortable? (not at all = 1, very = 5) 5
 - 6) Was the noise level comfortable? (noisy = 1, quiet = 5) 5
 - 7) Was our staff attentive to your needs? (not at all = 1, very = 5) 5
 - 8) How long do you think you slept last night? hrs min
 - 9) Did you have difficulty falling asleep last night? yes If so, why?: Different place
 - 10) Did you dream last night? yes
 - 11) Did you have any trouble breathing last night? no
 - 12) Do you remember moving in your sleep last night? yes
 - 13) Do any of the following describe how you feel this morning? Still sleepy
 - 14) How did the quality of sleep last night compare to your usual sleep at home? Better
 - 15) If you could use one word to describe your experience, what would it be? restful
- Please share with us how we could improve your visit. N/A
- Comments: Joan is an excellent technician. Very patient centered.

Author: Joan Merrill, RRT

Date and time completed: 3/23/2019 06:29

Electronically signed by Merrill, Joan, RRT at 3/23/2019 6:30 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F,			



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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)

Patient Demographics (continued)

DO570-887-2239

Contact Information

	Department	Har	Center
4/18/2019 2:45 PM	Rph Emergency Department		RPH

ED

4/18/2019

Jennifer Lyn Brown

MRN: 340616

Notes

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM

Author: Kniess, Carol Katherine, DO	Service: EMERGENCY MEDICINE	Author Type: Locum
Filed: 4/18/2019 5:17 PM	Date of Service: 4/18/2019 3:07 PM	Creation Time: 4/18/2019 3:07 PM
Status: Signed	Editor: Kniess, Carol Katherine, DO (Locum)	

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 4/18/2019

LOCATION: RPH EMERGENCY DEPARTMENT

History of Present Illness

Chief Complaint

Patient presents with

- Headache

HPI

42 yo woman who presents to ED with typical headache that starts with neck pain and spreads to the occipital area and then the vertex of the head, and to the left frontal area above the left eye/orbit. No photophobia, neck stiffness, recent trauma. Symptoms have been intermittent for years and today's symptoms are typical. She was seen by Guthrie physician yesterday and had injections for pain at her neck, which she has had before. States this usually resolves neck and head pain, but just resolved neck pain, though headache still present. Usually helps with headache too. Not worst headache of life. Not sudden in onset. Started gradually and insidiously 8 days ago. Undergoing a lot of stress with caring for family members and working. No vision changes, photophobia, floaters, halos, blurry vision, nausea, vomiting, fever, chills, sweats, stiff neck, abdominal/chest/back pain, leg pain or weakness, arm pain or weakness. No speech or swallowing problems. Had brief episodes of twitching in the area of her forehead above the left supraorbital ridge, lasting a few seconds, occurring a few times but are not present now. She states family practice wanted her to have a CT scan. Patient states she is walking and balancing ok. Feels she has been having memory issues over the



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)**ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)**

last several months, becoming forgetful, but working and caring for family, and feels this has been fatiguing. No face pain, nasal congestion. Has been prescribed multiple different medication for her pain, and declines pain medication at this time. No dizziness or lightheadedness.

Patient Active Problem List**Diagnosis**

- Plantar fascial fibromatosis
- Unspecified sinusitis (chronic)
- HTN (hypertension), benign
- GERD (Gastroesophageal Reflux Disease)
- Rheumatoid arthritis (HCC)
- Hyperhidrosis disorder
- Obesity
- GAD (generalized anxiety disorder)
- Nontoxic multinodular goiter
- ADHD (attention deficit hyperactivity disorder)
- Severe obstructive sleep apnea
- Environmental allergies
- Depression
- Fibromyalgia
- Status post bariatric surgery
- Tremor of left hand
- Benign head tremor
- Crohn's disease (HCC)
- Multiple benign nevi
- Cherry angioma
- Sun-damaged skin
- Neuritis
- Drug eruption
- Rash
- Long term current use of immunosuppressive drug
- Vitamin D deficiency
- Vitamin B12 deficiency
- Therapeutic drug monitoring
- Myopia of both eyes
- Bilateral dry eyes
- Pain in joint, upper arm
- Impingement syndrome of left shoulder

Past Medical History:**Diagnosis**

- Anal fissure
- Anxiety
- Attention deficit
- Back ache
- Calcaneal spur
- Cherry angioma
- Cholecystitis

Date
1/20133/18/2014
6/30/2008
8/9/2016



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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)

• CHRONIC SINUSITIS NOS CT 2005	5/23/2005
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0) Sees Dr. Freeman in Elmira.	12/12/2008
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR	N/A	6/24/2016
• COLONOSCOPY Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR	N/A	6/2/2017
• COLONOSCOPY Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR	N/A	6/11/2018
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;	N/A	8/13/2014
• EGD Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR	N/A	6/24/2016
• EGD Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR	N/A	6/2/2017
• EGD Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR	N/A	6/11/2018



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)

EGD (GUTHRIE / NON GUTHRIE)	
• LAPAROSCOPIC CHOLECYSTECTOMY <i>with liver biopsy</i>	2013
• PR CLOSED RX TARSAL FX, EACH	
• PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY <i>for obesity - Dr. Alley - RPH</i>	12/10/2014
• PR REMOVAL GALLBLADDER	
• TONSILLECTOMY	11/26/07

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry <i>Anxiety</i>	Mother	
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic <i>Marfan syndrome</i>	Father	
• Heart <i>?Marfan's Syndrome</i>	Father	
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart <i>Aortic Dissection, Marfan's Syndrome</i>	Paternal Uncle	
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry <i>ADHD</i>	Maternal Aunt	
• Genetic <i>Marfan syndrome</i>	Maternal Aunt	
• Psychiatry <i>ADHD</i>	Other	
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Social History



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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)**ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)****Tobacco Use**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics

- Alcohol use: No
- Alcohol/week: 0.0 oz
- Drug use: No

Current Facility-Administered Medications**Medication**

- saline (OCEAN) nasal spray 0.65 %

Current Outpatient Medications**Medication****Sig**

- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Place 1 Appl per rectum TWICE DAILY. Apply with cotton



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)

- | | |
|--|--|
| Ointment | applicator. |
| • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE | Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG Oral Tab EC | Take 1 Tab by mouth DAILY. |
| • Probiotic Product (VSL#3) Oral Cap | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn |
| • sulfasalazine (AZULFIDINE ENTABS) 500 MG Oral Tab EC | Take 2 Tabs by mouth TWICE DAILY. |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days |
| • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe | Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. |
| • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth DAILY. |
| • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth DAILY. |

Allergies

Allergen

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

- Swelling
- Rash
- Rash

Review of Systems

Negative except per HPI above. All systems reviewed.

Physical Exam

Temp: 98 °F (36.7 °C) (04/18/19 1416)

Pulse: 88 (04/18/19 1416)

Resp: 18 (04/18/19 1416)

BP: 149/77 (04/18/19 1416)

SpO2: 96 % (04/18/19 1416)

Physical Exam

Constitutional	No acute distress. Well appearing.
HEENT	Normocephalic. Atraumatic. No temporal artery tenderness. PERRL. EOMI. Cornea clear. Sclera white. Visual fields full to confrontation. Moist mucous membranes
Neck	Supple. Full, pain-free AROM. No meningismus.
Cardiovascular	Regular rate. Regular rhythm. No UE/LE swelling or tenderness
Pulmonary	Normal effort. No respiratory distress.
Abdominal	Soft. No tenderness, distention, rebound, rigidity, or guarding.



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)

Genitourinary	Deferred
Back	No focal tenderness
Musculoskeletal	Moves all extremities spontaneously.
Neurological	<p>Level of Consciousness: Awake and alert. Not drowsy. Not lethargic. Not unresponsive.</p> <p>Orientation: Oriented to person, place and time</p> <p>Cranial Nerves: CNs II-XII are intact. No diplopia. No nystagmus.</p> <p>Motor: Bilateral UE/LE MMT is 5/5. No abnormal tone. No clonus. No tremor.</p> <p>Sensation: Gross LT/PP sensation of Face/UE/LE is intact.</p> <p>Speech: No dysarthria. No aphasia.</p> <p>Coordination: Finger to nose intact. Heel to shin intact.</p> <p>Gait: steady without device, including standard gait and heel to toe gait. Normal unilateral balance.</p>
Skin	Warm. Dry. No rash, petechiae, or purpura. No external signs of trauma.
Psychiatric	Cooperative.

ED Course Procedures

Critical Care Time: Critical Care < 30 minutes excluding billable procedures.

Patient Progress: stable.

Vitals:

Temp: 98 °F (36.7 °C) (04/18/19 1416)

Pulse: 88 (04/18/19 1416)

Resp: 18 (04/18/19 1416)

BP: 149/77 (04/18/19 1416)

SpO2: 96 % (04/18/19 1416)

Assessment / Impression

1. Encounter for medical screening examination
2. Headache syndrome

Normal neuro exam

Chronic headache syndrome

Typical pain onset, location, character, quality

CT head requested by family practice



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Notes (continued)**ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM (continued)**

CT head shows no acute findings

Do not suspect meningitis, temporal arteritis, subarachnoid hemorrhage, optic neuritis, or other acute emergent disorder

Saw Dr. Attia yesterday for trigger point injection for chronic neck and head pain

Plan

Discharge home with PCP follow up

Continue working with pain management/Dr. Attia for trigger point therapy and pain management

May benefit from neurology evaluation if headaches become intractable

Electronically signed by Kniess, Carol Katherine, DO at 4/18/2019 5:17 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

4/28/2019 8:30 PM	Provider	Department	Har.	Center
	Rph Sleep Lab	Rph Sleep Lab		RPH

SLEEP STUDY TEST

4/28/2019

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM**

Author: Tigie, Yvonne
 Filed: 4/29/2019 5:42 AM
 Status: Signed

Service: — Author Type: Respiratory Therapist
 Date of Service: 4/28/2019 11:59 PM Creation Time: 4/29/2019 1:40 AM
 Editor: Tigie, Yvonne (Respiratory Therapist)

Guthrie Sleep Disorders Center
RPH Sleep Lab
1 Guthrie Square
Sayre PA 18840-1625
Tel 570-887-4639



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)**Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)****Patient:** Jennifer Lyn Brown**MRN:** 340616**Date of birth:** 10/26/1976**Study Type:** CPAP**Date of test:** 4/28/2019**Technician:** Yvonne Tigie, RPSGT**Room #:** 1**Acq #:** 1001319**Pre-Testing Questionnaire**

- 1) What time did you fall asleep last night? 930pm
- 2) What time did you wake up this morning? 10am
- 3) Was this a typical night's sleep for you? yes
If no, please explain: Day off this is normal
- 4) Approximately how many hours did you sleep...
Last night 8-9
Two nights ago 8-9
Three nights ago 6-7
- 5) How many naps did you have today? 0
How long?
- 6) How tired/sleepy are you now? (Wide awake = 1, Can't keep my eyes open = 10) 5
- 7) Has anything out of the ordinary happened to you recently? Please explain Dad died in Dec, grandmother died in Feb
- 8) Do you take medications to help you sleep? no Please list:
- 9) Have you taken any prescription or over the counter medications today? yes Please list:
See list
- 10) Do any occurrences during sleep concern you? Wake tired
- 11) Do you have any medical problems or sleep habits that the technician should be made aware? no
- 12) Did you consume any alcohol today? no
- 13) Did you consume any caffeine today? yes
- 14) Current vitals: Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m²

Technician Summary**Current medications:****Current Outpatient Medications**

Medication Sig

- buPROPion (WELLBUTRIN Take 1 Tab by mouth DAILY.
XL) 300 MG Oral TABLET



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)

SR 24 HR

- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks.
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)**Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)**

- ondansetron (ZOFran ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC Take 2 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications**Medication**

- saline (OCEAN) nasal spray 0.65 %

Technician Pretest Summary

Ms. Brown arrived on time for her sleep study. She is a very pleasant 42 year old. Her PMH includes: hypertension, rheumatoid arthritis, gastroparesis, GERD, anxiety, depression, fibromyalgia, attention deficit, back ache, chronic sinusitis, multinodular goiter and a previous diagnosis of OSA in 2013.

The patient had gastric sleeve surgery and quit using her CPAP after weight loss. She has been feeling more and more fatigued and thinks maybe she still needs the CPAP but no longer has the machine. She has regained some weight since then.

The patient has a history of severe daytime sleepiness and difficulty falling/staying asleep. She clenches her jaw when sleeping but does not wear a mouth guard. She was knocked unconscious in 1998 when she suffered a head injury.

The patient is aware of severe snoring. Her

Epworth Score is 4. The patient becomes drowsy when riding as a passenger for more than an hour or lying down to rest in the afternoon when circumstances permit. She typically does not nap. She is unaware of any apnea/abnormal breathing. The patient typically awakens unrefreshed. She typically consumes 2 caffeinated beverages a day. The patient has not been using any therapy at home but



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)

when she used CPAP before she used a full face mask and feels she would like to use it again.

14BPM

Time	Epoch	Stage	Position	SaO2	Modality
919pm	78	Wake	Supine	97-99	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	no	None	No snoring	75-84	Cals/pt cals done LIGHTS OUT CPAP 4cm cflex3

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
930pm	100	Wake	Right	98-99	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	no	None	No snoring	79-82	

Additional comments: 948pm TECH IN to fix leg lead

Time	Epoch	Stage	Position	SaO2	Modality
1001pm	161	Wake	Right	97	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Couple possible hypopnea/rera	No snoring	87-90	TECH IN to change ear lead

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
1030pm	220	3	Right	97-98	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Couple possible	No snoring	91-93	



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigue, Yvonne at 4/28/2019 11:59 PM (continued)

		hypopnea/ central			
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Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
11pm	280	3	Right	97	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible central, hypopnea/rera	No snoring	94-97	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
1130pm	340	3	Right	96-97	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/rera	No snoring	91-98	

Additional comments: 1134pm CPAP 5cm cflex3

Time	Epoch	Stage	Position	SaO2	Modality
12am	400	2	Right	97-99	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/rera	No snoring	79-87	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
1230am	460	2	Right	97-98	CPAP



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)

	Arousal s	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/ rera	No snoring	80-85	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
1am	520	2	Right	97-98	CPAP
	Arousal	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/ rera	No snoring	79-86	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
130am	580	2	Right	97-98	CPAP
	Arousal	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/ rera	No snoring	78-83	

Additional comments: 133am CPAP 6cm clflex3

Time	Epoch	Stage	Position	SaO2	Modality
2am	640	REM	Supine	95-97	CPAP
	Arousal	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/ rera	No snoring	75-80	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
230am	700	2	Supine	95	CPAP

Generated on 7/3/19 12:55 PM



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)

	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/rera	No snoring	72-76	

Additional comments: 256am CPAP 7cm cfex+1

Time	Epoch	Stage	Position	SaO2	Modality
3am	760	2	Supine	95	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible rera	No snoring	73-77	

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
331am	821	REM	Supine	96-100	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/rera	No snoring	74-79	CPAP 8cm cfex+2

Additional comments:

Time	Epoch	Stage	Position	SaO2	Modality
402am	884	REM	Supine	92-95	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea/rera	No snoring	129-150	CPAP 9cm cfex+3

Additional comments: 424am CPAP 10 cm cfex+3

Time	Epoch	Stage	Position	SaO2	Modality
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Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigie, Yvonne at 4/28/2019 11:59 PM (continued)

430	940	REM	Supine	93-95	CPAP
	Arousals	Respiratory Events	Snoring	HR	Comments
	yes	Possible hypopnea	No snoring	66-68	

Additional comments: 451am CPAP 11cm clflex+3, 458am pt woke moving mask, LIGHTS ON, cal/pt cal done

Mask type: Amara View FFM

Mask size: Medium

Final CPAP setting: 11cm H2O

Supplemental O2 Setting: None

Tolerance: Well

Humidifier: Heated

C-Flex: Plus 3

Chin Strap: None

Lights on: 458am

Lights off: 919pm

Bathroom visits: 0

Bed elevation: Flat

Number of pillows: 1

Post-Testing Questionnaire

How many hours/minutes do you think you slept? 8

How does this compare to the time you sleep at home? 6-8

Did you awaken during the night? yes

What caused you to awaken? mask

Was the mask you were wearing comfortable? yes

Were you able to tolerate the air pressure? yes

Did the CPAP machine make too much noise? no



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/28/2019, D/C: 4/28/2019

Notes (continued)

Progress Notes by Tigue, Yvonne at 4/28/2019 11:59 PM (continued)

Will you continue to try using the CPAP at home? yes

How was the room temperature during your test? perfect

How was the mattress/pillow during your test? comfortable

How was the noise level during your test? perfect

Were you able to get into your normal sleeping position? yes

If no, please describe why:

Were you treated in a professional and courteous manner by the technician? yes

Were all your questions and concerns answered? yes

Comments:

Author: Yvonne Tigue, RPSGT

Date and time completed: 4/29/2019 05:42

Electronically signed by Tigue, Yvonne at 4/29/2019 5:42 AM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

5/24/2019 6:00 AM	Department Rph Recovery	Har	Center RPH
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Admission

5/24/2019

Jennifer Lyn Brown

MRN: 340616



Notes Report 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

Notes (continued)**Notes****Discharge Summary by Marsiglio, Nicolas, RPA-C at 5/24/2019 11:25 AM**

Author: Marsiglio, Nicolas, RPA-C

Service: ORTHOPEDIC

Author Type: Physician Assistant

Filed: 5/27/2019 8:28 AM

Date of Service: 5/24/2019 11:25 AM

Creation Time: 5/27/2019 8:26 AM

Status: Signed

Editor: Marsiglio, Nicolas, RPA-C (Physician Assistant)

Cosigner: Choi, Joseph, MD at 5/28/2019 4:17 PM

GUTHRIE SP/OP DISCHARGE NOTE**Robert Packer Hospital****1 GUTHRIE SQUARE****SAYRE PA 18840****570-888-6666****PATIENT:** Jennifer Lyn Brown**SURGEON:** Primary: Choi, Joseph, MD**ASSISTING:** Nicolas Marsiglio, RPA-C**MRN:** 340616**DOB:** 10/26/1976**DATE OF SURGERY:** 5/24/2019**Procedure:** left shoulder arthroscopy, distal clavicle excision**Principle Diagnosis:** impingement syndrome and acromioclavicular joint arthritis - left**Associated Condition(s):** Same as pre-op, unless otherwise indicated**Mental Status:** Same as pre-op, unless otherwise indicated.**Condition:** Stable, unless otherwise indicated**Disposition of Care:** Discharge to home.**Appointment with/ or Follow-up with** Dr. Joseph Choi 2 weeks.

No orders of the defined types were placed in this encounter.



Notes Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

Notes (continued)

Discharge Summary by Marsiglio, Nicolas, RPA-C at 5/24/2019 11:25 AM (continued)

Other Comments: see discharge instructions

Author: Nicolas Marsiglio, RPA-C 5/27/2019

Electronically signed by Choi, Joseph, MD at 5/28/2019 4:17 PM



ROI Media Scans

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/30/2018

Scan on 11/9/2018 6:50 AM by Decker-Crippen, Brenda: EMG/Nerve Conduction Study - RPH (below)

EMG & NERVE CONDUCTION REPORT and CONSULTATION

340616
GordlineROBERT PACKER HOSPITAL
Sayre, PA

NAME: BROWN, JENNIFER LYN

Temperature: R Arm: Leg
L Arm: LegBN: 340616 DATE: 11/02/2018
VISIT #: 72859714

ROOM: OP AGE: 42Y TECH: LT

Weight: 265 lbs Height: 5'11"
Diabetic: N Diabetic Type: Handedness: R
Blood Thinner:
Document ID: 4421583REF: MICHAEL GORSLINE, PA-C
REF LOCATION: SECTION OF ORTHOPEDICS
NERVE CONDUCTION STUDIES

MOTOR NERVES	R-S	S-S	D	A	D-L	C-V	F	SENSORY NERVES	R-S	S-S	D	A	D-L
R Median	APB	Wrist	6	13.4	2.7		27	R Median	Index	Wrist	13	43	2.8
		Elbow	24.7	13.4	7.0	57			Mid	Wrist	13	45	2.7
L Median	APB	Wrist	6						Wrist	Palmar (mixed)	6	132	1.8
		Elbow						L Median	Index	Wrist	13		
R Ulnar	ADM	Wrist	6	8.6	2.7		26		Mid	Wrist	13		
		Elbow	22.6	8.2	5.4	83			Wrist	Palmar (mixed)	8		
		A/E bow	32.0	8.0	8.0	80		R Ulnar	V	Wrist	11	49	2.6
L Ulnar	ADM	Wrist	6						Wrist	Palmar (mixed)	8	32	2.0
		Elbow							V	Wrist	11		
		A/E bow						L Ulnar	Wrist	Palmar (mixed)	8		
R Peroneal	EDB	Ankle	8					R Radial	DOH	Forearm	10	25	2.3
		Pop Fossa							DOH	Forearm	10		
L Peroneal	EDB	Ankle	8					R Mus. Out.	Forearm	Forearm	12		
		Pop Fossa							Forearm	Forearm	12		
R Tibial	AH	Ankle	8					R Sural	Ankle	Leg	10		
		Pop Fossa							Ankle	Leg	10		
L Tibial	AH	Ankle	8					R S Peroneal	Ankle	Leg	10		
		Pop Fossa							Ankle	Leg	10		
R H-reflex	Soleus							R M Plantar	Ankle	Sole	10		
L H-reflex	Soleus								Ankle	Sole	10		
R Ulnar	FDI	Wrist	12					R L Plantar	Ankle	Sole	10		
L Ulnar	FDI	Wrist	12						Ankle	Sole	10		
								R Median	Ring	Wrist	12	31	2.7
								R Ulnar	Ring	Wrist	12	30	2.9
								L Median	Ring	Wrist	12		
								L Ulnar	Ring	Wrist	12		
								R DUC	Hand	Arm	10	22	2.5
								L DUC	Hand	Arm	10		

CLINICAL HISTORY: This is a 42-year-old lady with a history of tendinitis of the right elbow, and the patient has been having some intermittent numbness involving medial aspect of the right forearm and also pinky finger. Testing was performed to rule out any ulnar neuropathy or cubital tunnel syndrome.

DESCRIPTION OF STUDY: Sensory nerve conduction study was performed on the right median, right ulnar, and right radial nerve. Right median sensory nerve action potential was 45 with a distal latency of 2.7, palmar mixed 132 with a 1.8. Right ulnar 49 with a 2.6, palmar mixed 32 with a 2.0. Right radial 25 with a 2.3. Motor nerve conduction study was performed on the right median and right ulnar nerve. Right median compound muscle action potential was 13.4 with a distal latency of 2.7. Right ulnar 8.6 with a 2.7. Conduction velocity and F-wave responses are unremarkable.

ABBREVIATIONS: R-S = Record Site	D = Distance	D-L = Distal Latency	F = F Wave
NR = No response	S-S = Stimulus site	A = Amplitude	C-V = Conduction Velocity

Page 1 of 2


 141907120000303
 ROI Media Scans

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/30/2018

340616

NEEDLE ELECTROMYOGRAPHY

RIGHT MUSCLE				LEFT MUSCLE			
SPONT. ACTIVITY	FASCIC	RECRUIT-MENT	MUP DESCRIPTION	SPONT. ACTIVITY	FASCIC	RECRUIT-MENT	MUP DESCRIPTION
			CERVICAL PARASPINAL C4...8				
			RHOMBROID C5: dorsal scapular				
			SERRATUS ANTERIOR C6,5,7: Long thor				
			INFRAPIRAPHIUS C5,C6: supscap				
0	0	N	N				
			DELTOID C5,C6: axillary				
			BICEPS C5,C6: musculocutaneous				
0	0	N	N				
			BRACHIORADIALIS C5,C6: radial				
			TRICEPS C7,C8,T1: radial				
			PRONATOR TERES C6,C7: median				
0	0	N	N				
			EXT DIGITI COMMUNIS C7,C8: radial				
			FLX CARPI RADIALIS C7,C8,C9: median				
0	0	N	N				
			FLX CARPI ULNARIS C8,T1: ulnar				
			EXT CARPI ULNARIS C7,C8,C9: radial				
0	0	N	N				
			ABDUCTOR DIGITI MIN C8,T1: ulnar				
0	0	N	N				
			ADD POLICIS BREVIS C8,T1: median				
			1st DOR INTEROSSEOUS C8,T1: ulnar				
			LUMBAR PARASPINAL L1...S1				
			PSOAS L3,L4: lumbar plexus				
			GLUTEUS MEDIUS L5,S1: sup gluteal				
			GLUTEUS MAXIMUS S1,L5,S2: inf gluteal				
			RECTUS FEMORIS L4,L5: femoral				
			VASTUS LATERALIS L4,L5: femoral				
			ADDUCTOR MAGNUS L3,L4: obturator				
			SEMITENDINOSUS L5,S1: tibial				
			SHORT HEAD BICEPS S1,L5: peroneal				
			TIBIALIS POSTERIOR L5,S1: tibial				
			TIBIALIS ANTERIOR L4,L5: peroneal				
			PERONEUS LONGUS L5,S1: peroneal				
			EXT HALLUCIS LONGUS L5,S1: peroneal				
			MEDIAL GASTROCNEMIUS S1,S2: tibial				
			LATERAL GASTROCNEMIUS S1,S2: tibial				
			ABDUCTOR HALLUCIS S1,S2: tibial				
			EXT DIGITI BREVIS L5,S1: peroneal				

Needle EMG study was carried out in selected muscle groups including right-side FDI, ADM, FCB, EDC, triceps and biceps muscle. I did not appreciate any significant evidence of sustained fibrillation potentials noted. No evidence of significant major denervation changes noted. Recruitment of the motor unit is fairly unremarkable.

CONCLUSION: Essentially normal study without significant evidence of any ulnar neuropathy or carpal tunnel syndrome noted at the present time.

CC: MICHAEL GORSLINE, PA-C
SECTION OF ORTHOPEDICS

PT NAME: BROWN, JENNIFER LYN
PT BN: 340616
DATE: 11/02/2018
HSK, RC SL3

NEUROLOGIST

HAN BURK KOH, MD, CHIEF

ABBREVIATIONS: MUP=Motor Unit Potential, S=Serrated; CRD=Complex Repetitive Discharge; HA=High Amplitude; LA=Low Amplitude;
FASCIC=Fasciculation; F=Fibrillations; SD=Short Duration; MYO=Myokymia; PW=Positive Wave; M=Myotonia; P=Polyphasia; LD=Long Duration;
N=Normal

Page 2 of 2



GUTHRIE

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
ROI Media Scans

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

Scan on 3/29/2019 1:13 PM by Decker-Crippen, Brenda: Nocturnal Polysomnogram Report - RPH (below)

B#: 340616
Physician: GILLAN

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 18840
(570)-887-4939

NOCTURNAL POLYSOMNOGRAM REPORT

Patient name:	BROWN, JENNIFER	Acq. #:	1001288
GHS MRN:	340616	Type:	NPSG
Sex:	F	Started:	3/22/2019 at 8:41:10 PM
Birth date:	10/26/1976	Stopped:	3/23/2019 at 6:03:16 AM
Age:	42 years	Duration:	8:22:06 (502.1 min)
Height:	5' 11"	Weight:	286 lbs
BMI:	39.89 kg/m2	Epworth Score:	4 / 24
Referring Physician:	Gillan, DO, Michael	Ordering Physician:	GILLAN, MICHAEL
Interpreting Physician:	Dr. Han Suk Koh	Scoring Tech:	Yvonne Tigus, RPSGT
		Acquiring Tech:	Joan Manjarriz

This multi-channel overnight study consists of a combination of the following: frontal, central and occipital EEG, electrooculogram (EOG), submental EMG (chin), anterior tibialis EMG, body position and electrocardiogram. Additional parameters monitored include: belts using ZRIP technology for thoracic and abdominal effort, airflow measured via nasal pressure transducer and nasal/oral thermistor, pulse oximetry for SA02, one channel for snoring, and digital video recording. The tracing was scored using 30 second epochs. Hypopneas were scored per AASM definition 1B with 4% desaturations.

DEFINITIONS:

Apnea: cessation of inspiratory airflow for ten seconds or longer.Hypopnea: reduction in airflow by 30-90% followed by a desaturation \geq 4%.Central: cessation of inspiratory airflow and respiratory effort for ten seconds or longer.Obstructive: cessation of inspiratory airflow with continued respiratory effort for ten seconds or longer.

INTERPRETATION

Nocturnal Polysomnogram Shows:

Respiratory: 35 episodes with AHI of 5.4 and an RDI of 10.3Oximetry: Baseline was 95% and maximal desaturation was 84% associated with sleep apneasLeg movements: 16 episodes with index of 2.5/hr.EEG data: 85.2% sleep efficiency with prominent stage 2 sleepEKG data: SR

CONCLUSION:

Abnormal study with mild obstructive sleep apneas with an AHI 5.4 of RDI of 10.3 and 84% % desaturation was noted.

Patient came with Epworth Sleepiness Score of 4 points and snoring history at home. Moderate snoring was noted in this study. Patient went to REM stage of sleep and delta wave sleep. Sleep efficiency was 85.2% and sleep onset latency of 9.4 minutes. No oxygen was required. One episode of central apnea was noted out of total 66 episodes. No periodic breathing or cardiac arrhythmia was noted. No periodic limb movement disorder was noted. REM specific AHI was 8.7/h. Patient has a history of sleep apnea using CPAP until she had a bariatric surgery and weight loss. However, patient still feels tired.

Consider CPAP titration study, weight reduction program and good sleep hygiene.

Dr. Han Suk Koh
AASM Diplomate in Sleep Medicine
ABMS Diplomate in Sleep Medicine

Please cc: report to referring provider. Call (570) 887-2838 to set up an appointment with one of our sleep specialists.



ROI Media Scans

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

B#: 340616
Physician: GILLAM**Guthrie Sleep Disorders Center****Robert Packer Hospital**1 Guthrie Square • Sayre, PA 18840
(570)-887-4839

SLEEP ARCHITECTURE			
Recording time	502.1 min	WASO	10.0 min
Total Sleep Time (minutes)	385.5	Light off (LO)	10:44:16 PM
Sleep Efficiency %	95.2	Light on (LON)	5:29:16 AM

Distribution	From Light off (min)	duration	TST%
Sleep onset	9.4		
N1	9.4	23.5	6.1
N2	12.4	229.0	59.4
N3	40.9	91.5	23.7
REM	255.4	41.5	10.8

RESPIRATORY EVENT SUMMARY

Apnea-Hypopnea Index (average number of apneas and hypopneas per hour of actual recorded sleep)

	Total	REM	NREM	Supine	Rt Side	Lt Side
AHI	5.4	8.7	5.1	12.9	1.8	
Time in Min	385.5	41.5	344.0	127.5	258.0	
RDI	10.3	9.8	13.0			

RESPIRATORY EVENT SUMMARY

	CA	OA	MA	Sum Ap	HYP	A + H Events	RERA	Resp. Events
Number	4	0	0	4	31	35	31	66
Index (#/h TST)	0.6	0.0	0.0	0.6	4.8	5.4	4.8	10.3

CHEYNE STOKES RESPIRATIONS

Cheyne Stokes Breathing

None

OXIMETRY DATA

Ave. O2 while awake	96	Approximate minimum O2 value	84
Total Sleep w/SAO2<90%	40.5 min.	Total Sleep w/SAO2<70%	0.0 min.
Total Sleep w/SAO2<80%	0.0 min.	Total Sleep w/SAO2<60%	0.0 min.
# Episodes (>= 5.0 minutes) SpO2 < 88 %	0		
Longest duration SpO2 < 88 % (>= 5.0 minutes)	0.0 minutes		
Desat Index (#/hour)		WK	REM
		9.5	7.2
			NREM
			4.7

Mean of the resp. event O2 min levels [%]	91
Mean of the resp. event O2 min levels with desat [%]	86
Minimum of the resp. event O2 min levels [%]	84

Respiratory event O2 min levels



GUTHRIE

141907120000303
ROI Media Scans

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

B#: 340616
Physician: GILLAM

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 18840
(570)-887-4839

OXIMETRY DETAIL

	WK	REM	NREM	TOTAL
<80 (min)	0.0	0.0	0.0	0.0
<90 (min)	0.5	0.2	39.8	40.5
<98 (min)	0.0	0.0	1.8	1.8
Fall (mm)	0.5	0.0	12.9	13.4
Average (%)	86	95	85	95

MOVEMENT SUMMARY

Total number of PLM episodes	2
PLM Index (#/h)	0.3
PLM Arousal Index	1
Total number of Leg movements	16
Leg Movement Index	2.5
Number of arousals associated with leg movements	0

AROUSAL SUMMARY

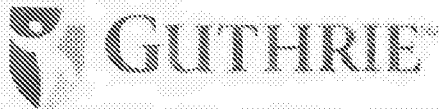
Total number Arousals : 81
Arousal Index : 16.7/h(sleep)

CARDIAC SUMMARY

Average Heart Rate During Sleep:	88.6 bpm
Highest Heart Rate During Sleep:	116 bpm
Highest Heart Rate During Recording (TIB):	116 bpm

CARDIAC EVENT OBSERVATIONS

TYPE	YES	NO	RATE / DURATION
Bradycardia:		✓	Lowest HR Scored: N/A
Unclassified Tachycardia:		✓	Highest HR Scored: N/A
Sinus Tachycardia During Sleep:		✓	Highest HR Scored: N/A
Narrow Complex Tachycardia:		✓	Highest HR Scored: N/A
Wide Complex Tachycardia:		✓	Highest HR Scored: N/A
Asystole:		✓	Longest Pause: N/A
Atrial Fibrillation:		✓	Duration Longest Event: N/A



ROI Media Scans

Brown, Jennifer Lyn

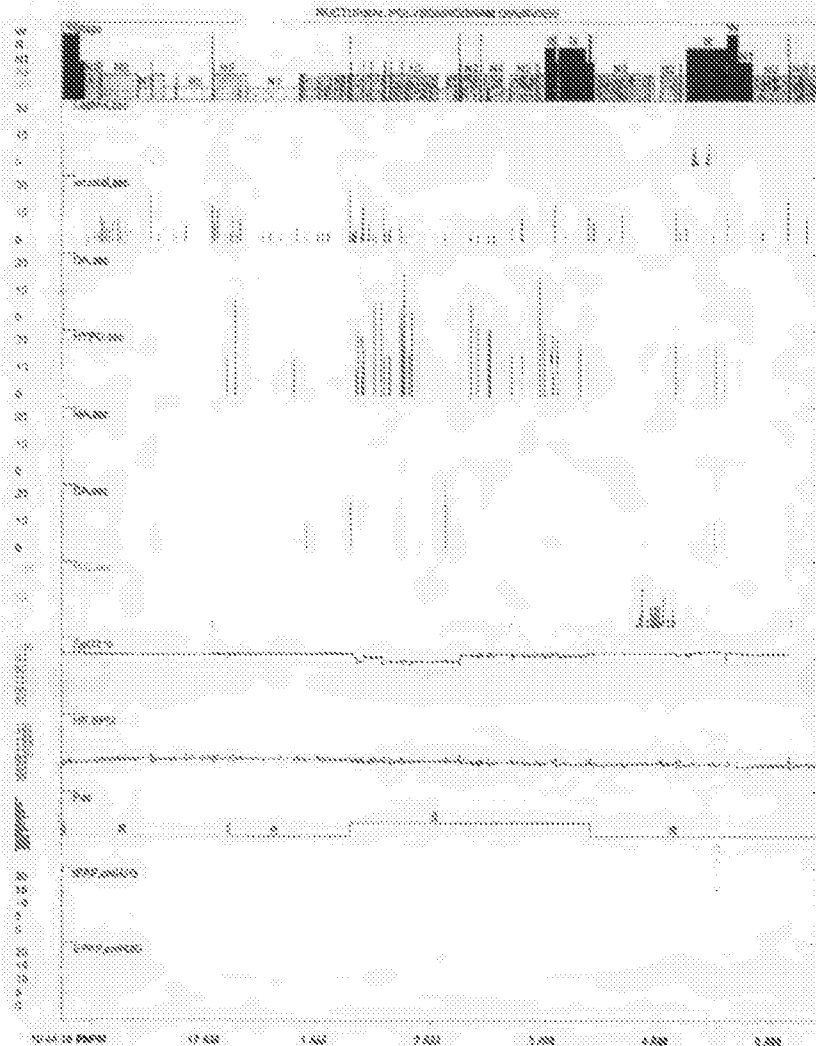
MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/31/2019

141907129900383

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 16840
(570) 887-4823ID# 340616
Physician: GILMAN



ROI Media Scans

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

Scan on 5/2/2019 5:56 AM by Decker-Crippen, Brenda: PAP Titration Report - RPH (below)

B#: 3642195
Physician: GILLAN**Guthrie Sleep Disorders Center****Robert Packer Hospital**1 Guthrie Square • Sayre, PA 18840
(570)-887-4839**PAP TITRATION REPORT**

Patient name:	BROWN, JENNIFER	Acq. #:	1001319
GHS MRN:	3612198	Type:	PAP
Sex:	F	Started:	4/28/2019 at 8:41:14 PM
Birth date:	10/26/1976	Stopped:	4/29/2019 at 5:25:28 AM
Age:	42 years	Duration:	8:45:12 (525:2 min)
Height:	71.0	Weight:	286.0
BMI:	39.9 kg/m2	Epworth Score:	4 / 24
Referring Physician:	Gillan, DO, Micheal	Ordering Physician:	GILLAN, DO, MICHAEL
Interpreting Physician:	Dr. Han Suk Koh	Scoring Tech:	Yvonne Tighe RPSGT
		Acquiring Tech:	Yvonne Tighe RPSGT

This multi-channel overnight study consists of a combination of the following: frontal, central and occipital EEG, electrooculogram (EOG), submentalis EMG (chin), anterior tibialis EMG, body position and electrocardiogram. Additional parameters monitored include: belts using ZRIP technology for thoracic and abdominal effort, airflow measured via nasal pressure transducer and nasal/oral thermistor, pulse oximetry for SA02, one channel for snoring, and digital video recording. The tracing was scored using 30 second epochs. Hypopneas were scored per AASM definition 1B with 4% desaturations.

DEFINITIONS:**Apnea:** cessation of inspiratory airflow for ten seconds or longer.**Hypopnea:** reduction in airflow by 30% followed by a desaturation \geq 4%.**Central:** cessation of inspiratory airflow and respiratory effort for ten seconds or longer.**Obstructive:** cessation of inspiratory airflow with continued respiratory effort for ten seconds or longer.**INTERPRETATION****PAP Titration Shows:****Respiratory:** Gradual CPAP titration with good AHI reduction to 4.6/h at 10 cm of water pressure. Patient tolerated the procedure well.**Oximetry:** Baseline was 96% and maximal desaturation was 85% associated with sleep apneas.**Leg movements:** 29 episodes with index of 4.2/hr.**EEG data:** 89.6% sleep efficiency with prominent stage 2 sleep.**EKG data:** SR**CONCLUSION:**

Good response to CPAP was noted.

Patient came with Epworth Sleepiness Score of 4 points and snoring history at home. Light snoring was noted in this study. Patient underwent Polysomnography in March 2019 revealing mild degree obstructive sleep apnea with AHI of 10.3/h and 84% of desaturation. Patient went to REM stage of sleep and delta wave sleep in this study. Sleep efficiency was 89.6% with sleep onset latency of 12.8 minutes reflecting possible insomnia or first night effect. No oxygen was required. 3 episodes of central apnea were noted. No periodic breathing or cardiac arrhythmia was noted. No periodic limb movement disorder was noted. CPAP titration was initiated at 4 cm and gradually increased to 11 cm with good tolerance of patient. Good AHI reduction was noted at the 10 cm. No snoring was noted at the 10 cm. REM stage of sleep and supine position were noted at the 10 cm.

Consider CPAP at 10 cm of water pressure with heated humidifier, weight reduction program, and good sleep hygiene.

This report contains critical information. Please call report to referring provider.



Dr. Han Suk Koh
AASM Diplomate in Sleep Medicine
ABMS Diplomate in Sleep Medicine


GUTHRIE

 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
 ROI Media Scans

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

 B#: 3612168
 Physician: GILLAN

Guthrie Sleep Disorders Center
Robert Packer Hospital

 1 Guthrie Square • Sayre, PA 18840
 (570)-867-4639

CPAP INFORMATION

Unit:	Ominlab	Mask Size: Medium	C-Flax: Plus 2
Chin Strap:	None	Mask Type: Amara View FFM	
Humidifier:	Heated	Tolerance: Well	Oxygen: None

SLEEP ARCHITECTURE

Recording time	525.2 min	WASO	34.0 min
Total Sleep Time (minutes)	411.0	Light off (LO)	8:19:58 PM
Sleep Efficiency %	89.6	Light on (LON)	4:58:44 AM

Distribution	From Light off (min)	duration	TST%
Sleep onset	12.8		
N1	12.8	48.0	11.7
N2	48.3	175.5	42.7
N3	69.3	71.0	17.3
REM	257.6	118.5	28.3

RESPIRATORY EVENT SUMMARY

Apnea-Hypopnea Index (average number of apneas and hypopneas per hour of actual recorded sleep)

	Total	REM	NREM	Supine	Rt Side	Lt Side
AHI	2.5	6.7	0.8	4.5	0.8	
Time in Min	411.0	118.5	294.5	195.2	248.6	
RDI	9.6	9.6	9.6			

RESPIRATORY EVENT SUMMARY

	CA	OA	MA	Sum Ap	HYP	A + H Events	RERA	Resp. Events
Number	3	1	0	4	13	17	49	86
Index (#/h TST)	0.4	0.1	0.0	0.6	1.9	2.5	7.2	9.6

CHEYNE STOKES RESPIRATIONS

Cheyne Stokes Breathing

None



1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
 ROI Media Scans Brown, Jennifer Lyn
 MRN: 340616, DOB: 10/26/1976, Sex: F
 Visit date: 3/29/2019

B#: 3612198
 Physician: GILLAN

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 18840
 (570)-887-4839

OXIMETRY DATA

Ave. O2 while awake 98 Approximate minimum O2 value: 85
 # Episodes (≥ 5.0 minutes) $SpO_2 < 88\%$: 0

Desat Index (#/hour)

WK	REM	NREM
0.0	12.4	0.0

Total number of PLM episodes	4
PLM Index (#/h)	0.6
PLM Arousal Index	1
Total number of Leg movements	29
Leg Movement Index	4.2
Number of arousals associated with leg movements	0

AROUSAL SUMMARY

Total number Arousals : 87
 Arousal Index : 15.6h(sleep)

CARDIAC SUMMARY

Average Heart Rate During Sleep:	80.5 bpm
Highest Heart Rate During Sleep:	107 bpm
Highest Heart Rate During Recording (TIB):	118 bpm

CARDIAC EVENT OBSERVATIONS

TYPE	YES	NO	RATE / DURATION
Bradycardia:		✓	Lowest HR Scored: N/A
Unclassified Tachycardia:		✓	Highest HR Scored: N/A
Sinus Tachycardia During Sleep:		✓	Highest HR Scored: N/A
Narrow Complex Tachycardia:		✓	Highest HR Scored: N/A
Wide Complex Tachycardia:		✓	Highest HR Scored: N/A
Asystole:		✓	Longest Pause: N/A
Atrial Fibrillation:		✓	Duration Longest Event: N/A



ROI Media Scans

Brown, Jennifer Lyn

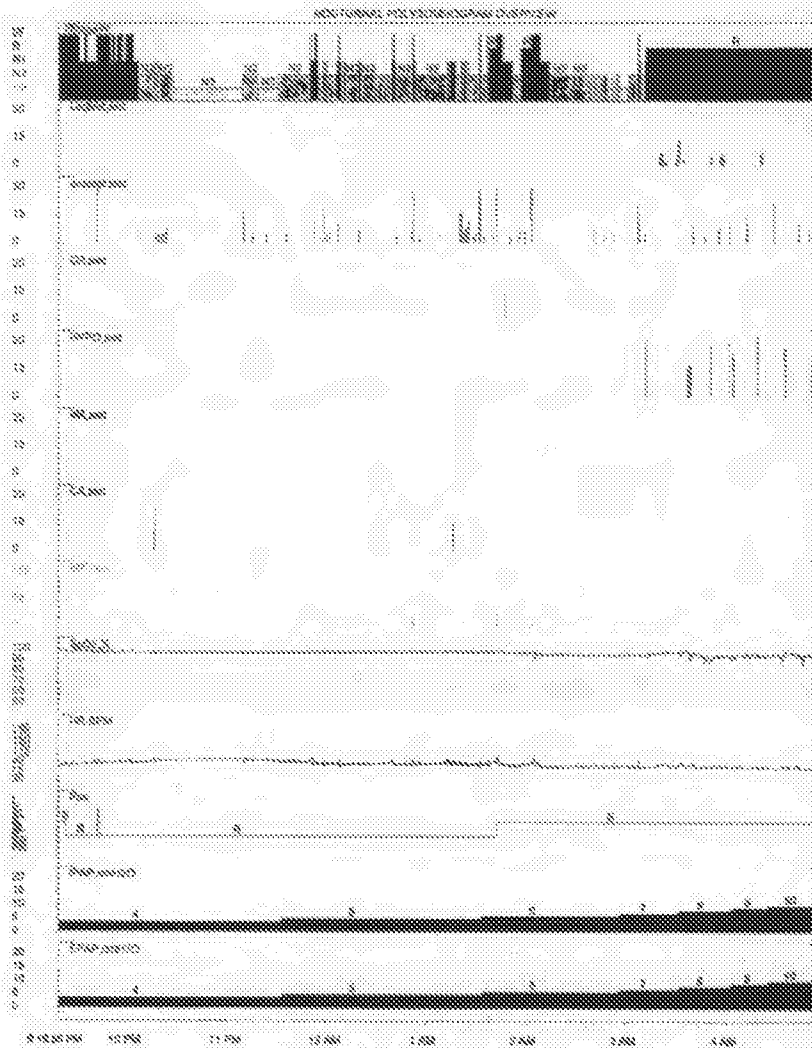
MRN: 340816, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

SS: 3612158
Physician: DELAN

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 16840
(870)-887-4639



ROI Media Scans

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

BM: 3612198
Physician: GILLAN**Guthrie Sleep Disorders Center****Robert Packer Hospital**1 Guthrie Square • Sayre, PA 18840
(570)-887-4639**PAP PRESSURE DISTRIBUTION**

IPAP	EPAP	TIB (min)	Sleep (min)	REM (min)	Apneas				Hypopneas		RERAs		AHI	RDI	Minimum SpO2
					CA#	OA#	MA#	Index	#	Index	#	Index			
4	4	121.3	101.8	0.0	2	0	0	1.2	0	0.0	9	5.3	12	6.5	95
5	5	119.6	115.1	0.0	1	0	0	0.5	0	0.0	27	14.1	0.5	14.6	95
6	6	82.2	72.7	10.5	0	1	0	0.8	0	0.0	9	7.4	0.8	8.3	93
7	7	34.6	34.1	19.6	0	0	0	0.0	1	1.8	2	3.5	1.8	5.3	86
8	8	31.2	31.2	31.2	0	0	0	0.0	5	9.6	0	0.0	9.6	9.6	87
9	9	21.5	21.5	21.5	0	0	0	0.0	3	8.4	1	2.8	8.4	11.2	88
10	10	26.3	26.3	26.3	0	0	0	0.0	2	4.6	1	2.3	4.6	6.8	88
11	11	6.1	6.1	6.1	0	0	0	0.0	2	19.7	0	0.0	19.7	19.7	86


 141907120000303
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Admission Information

Arrival Date/Time:	Admit Date/Time:	06/11/2018 6:58 AM	IP Adm. Date/Time:
Admission Type: Elective	Point of Origin:	Nonhealthcare Facility Point Of Origin	Admit Category:
Means of Arrival:	Primary Service:	Gastroenterology	Secondary Service:
Transfer Source:	Service Area:	GUTHRIE CLINIC	Unit: RPH RECOVERY
Admit Provider: McDonald, Thomas J, MD	Attending Provider:	McDonald, Thomas J, MD	Referring Provider: Gillan, Michael F, DO

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/11/2018 9:42 AM	Home Or Self Care (Routine)	None	None	RPH RECOVERY

AP / SURGICAL SPECIMEN (Order 143349297)
 Status: Edited Result - FINAL
 (Collected: 6/11/2018 11:00 AM)
AP / SURGICAL SPECIMEN [143349297]
 Resulted: 06/12/18 1114, Result status: Edited
 Result - FINAL

Ordering provider: McDonald, Thomas J, MD 06/11/18 1057 Filed by: Interface, Copath Results 06/12/18 1115

Resulting lab: CORNING HOSPITAL LABORATORY

Acknowledged by

Gillan, Michael F, DO on 06/12/18 1118

McDonald, Thomas J, MD on 06/12/18 1128

Bell, Janine, RN on 06/12/18 1254

Specimen Information

Type	Source	Collected On
Other	—	06/11/18 1100

Components

Component	Value	Reference Range	Flag	Lab
Sp Final Report Result:	--	—	—	CH

Patient Name: BROWN, JENNIFER LYN


 141907120000303
 Pathology Result Report Brown, Jennifer Lyn

 MRN: 340616, DOB: 10/26/1976, Sex: F
 Adm: 6/11/2018, D/C: 6/11/2018
Notes (continued)

MRN#: 340616
 Date of Birth: 10/26/1976 (Age: 41)
 Gender: F
 Specimen #SP18-10753

Source:

- 1: Cold bx Gastric antrum
- 2: Cold bx sigmoid/rectum

Final Pathologic Diagnosis

1. Stomach, antrum; biopsy:
 - Antral mucosa with mild-moderate chronic gastritis and reactive/regenerative changes
 - Negative for intestinal metaplasia or dysplasia
 - No Helicobacter pylori bacilli are identified on routine microscopy
2. Colon, sigmoid; cold biopsy:
 - Focal active colitis (see comment)
 - Negative for dysplasia

Comments

Specimen 2: No significant architectural distortion, crypt abscesses, or granulomas are identified. The differential diagnosis includes infectious causes, medications and inflammatory bowel disease.

Electronically Signed by HANI HOJJATI MD on 6/12/2018

11:14:54

Gross Description

1. Received in formalin labeled with name medical record number and "antrum biopsy", consisting of 2 white gray tissue fragment measuring 0.4 and 0.3 cm, entirely submitted.
2. Received in formalin labeled with name medical record number and "sigmoid colon", consisting of 6 gray irregular tissue fragments ranging from 0.5 to 0.3 cm in largest dimension, entirely submitted.

Microscopic Description

Microscopic examination performed
 HANI HOJJATI MD


 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
 Pathology Result Report Brown, Jennifer Lyn

 MRN: 340616, DOB: 10/26/1976, Sex: F
 Adm: 6/11/2018, D/C: 6/11/2018

Notes (continued)

View Image (below)

Guthrie Medical Group Laboratories
 Laboratory Medical Director: Rick Hartman, DO
 Department of Anatomic Pathology
 Guthrie Square
 Sayre, PA 18840
 Phone (570)887-4160 Fax (570)887-4193
Surgical Pathology Report
 Pathologists: Javad Beheshti, MD Perry Bradstreet, MD Dilip Gupta, MD
 Rick Hartman, DO Hani Hojjati, MD Ashit Sarker, MD PhD

Patient Name:	BROWN, JENNIFER LYN	Accession #:	SP18-10753
Med. Rec. #:	340616	Client:	Guthrie Healthcare
DOB:	10/26/1976 (Age: 41)	Location:	PACU
Gender:	F	Service:	
Billing #:	69394950	Taken:	6/11/2018 11:00
Physician(s):	THOMAS J MCDONALD JR MD	Received:	6/11/2018 12:38
		Reported:	6/12/2018 11:14
		Copy To:	

Clinical Information

GERD, Hx Crohn's

Pre Op Diagnosis

GERD, Hx Crohn's

Post Op Diagnosis

same

Specimen Received/Procedure
 1: Cold bx Gastric antrum
 2: Cold bx sigmoid/rectum
Final Pathologic Diagnosis

1. Stomach, antrum; biopsy:
 - Antral mucosa with mild-moderate chronic gastritis and reactive/regenerative changes
 - Negative for intestinal metaplasia or dysplasia
 - No Helicobacter pylori bacilli are identified on routine microscopy
2. Colon, sigmoid; cold biopsy:
 - Focal active colitis (see comment)
 - Negative for dysplasia

Comments

Specimen 2: No significant architectural distortion, crypt abscesses, or granulomas are identified. The differential diagnosis includes infectious causes, medications and inflammatory bowel disease.

htx/6/12/2018

Electronically Signed by HANI HOJJATI MD on 6/12/2018 11:14:54

BROWN, JENNIFER LYN

Page 4 of 2

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
Pathology Result Report Brown, Jennifer LynMRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 6/11/2018, D/C: 6/11/2018

Notes (continued)

Guthrie Medical Group Laboratories

SP18-10753

Gross Description

1. Received in formalin labeled with name medical record number and "antrum biopsy", consisting of 2 white gray tissue fragment measuring 0.4 and 0.3 cm, entirely submitted.
2. Received in formalin labeled with name medical record number and "sigmoid colon", consisting of 6 gray irregular tissue fragments ranging from 0.5 to 0.3 cm in largest dimension, entirely submitted.

July 9/11/2018

Microscopic DescriptionMicroscopic examination is performed
hdx6/12/2018

HANI HOJJATI MD

If performed, the adequacy of the special histochemical stains is verified by appropriate positive and negative controls. All automated immunohistochemistry and direct immunofluorescence assays performed use analyte specific reagents (ASR). Their performance characteristics have been validated in-house. The US Food and Drug Administration (FDA) have not reviewed these assays. The FDA has determined that such clearance or approval is not necessary. These assays are used for clinical purposes, and are not regarded as investigational or for research. The adequacy of staining is verified by appropriate positive and negative controls. Technical components are performed at the Guthrie Medical Group laboratory, 1 Guthrie Square, Sayre, PA 18840.

BROWN, JENNIFER LYN

MRN: 340616

Page 2 of 2

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
11 - CH	CORNING HOSPITAL LABORATORY	Hartman, Ricky E, DO	1 Guthrie Drive Corning NY 14830	02/27/16 0000 - Present



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

**CT ABDOMEN PELVIS WITH IV
CONTRAST (Accession 5411472) (Order
142758526)**

Imaging Information**Exam Information**

Performed Procedure	Study Status	Begin Time	End Time
CT ABDOMEN PELVIS WITH IV CONTRAST	Final	Sat May 26, 2018 9:02 AM	Sat May 26, 2018 9:20 AM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Kisel, Lisa, RT	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Kostick, Richard, DO	May 26, 2018

Study Result

Procedure(s): CT ABDOMEN PELVIS WITH IV CONTRAST
Date of service: 5/26/2018 9:02 AM

Provided clinical information: 41 years, Female, "Patient with abdominal pain history of Crohn's disease. Abdominal pain is greatest in right lower quadrant"

Procedure and materials: Standard protocol.

Contrast: With IV contrast

Comparison studies: 12/7/2017 with some interval change

Observations:

LOWER LUNGS AND HEART: Within normal limits

MAJOR ORGANS: Within normal limits and the patient is status post cholecystectomy.

PELVIC ORGANS: The uterus and vaginal fornices as well as urinary bladder are within normal limits. Small follicular cysts noted within the left ovary with a fairly prominent cyst measuring 4.7 x 4 cm located within the right ovary.

BOWEL PATTERN: Patient is status post partial gastrectomy or bariatric surgery. There is a nonobstructed bowel pattern. The ileocecal valve



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Imaging Information (continued)**Study Result (continued)**

is patent. The terminal ileum has no abnormal wall thickening.

PERITONEUM: Within normal limits

APPENDIX: Within normal limits

LYMPHADENOPATHY: There are a few small numerous lymph nodes in the right lower quadrant of the abdomen which are again seen and slightly larger than on the previous examination with the largest dimension being 8 mm in axial dimension seen on axial image 109.

FREE AIR: None

FREE FLUID: None

ARTERIAL SYSTEM: Within normal limits

BONES: Within normal limits

OTHER: None

IMPRESSION**IMPRESSION:**

Fairly prominent cyst in the right ovary measuring 4.7 x 4 cm which most likely is accounting for the patient's symptoms, however, there are also mildly prominent lymph nodes in the right mid to lower abdomen with the largest measuring 8 mm in axial dimension which also could be suggestive of a mesenteric panniculitis. Clinical correlation is recommended

No definite masses, free air or free fluid seen

No evidence of inflammatory bowel disease

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Kostick, DO on 5/26/2018 9:40 AM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam**GHS CONTRAST SHEET**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	
2. Was contrast sheet verified?	Yes	
3. Is the patient pregnant?	No	
4. Comments:		
5. When was your LMP?		



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Imaging Information (continued)

Questionnaire (continued)

End Exam

RIS END CONTRAST

Question	Answer	Comment
1. Type of contrast administered:		
2. Contrast amount (mL)?		
3. Who administered the contrast?		
4. Contrast expiration date?	6/12/2020	
5. Contrast lot#?	13773372	
6. Injection Site	Antecubital	
7. Was contrast type and amount verified in the charges section above?	Yes	
8. Confirm Resource:	RPH CT ROOM 2 [600022]	
9. Was this sent to after hours reading service (VRC-Nighthawk)		
10. Did you utilize a nurse for this exam?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

US PELVIC COMPLETE WITH DOPPLER
(Accession 5411493) (Order 142758531)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
US PELVIC COMPLETE WITH DOPPLER	Final	Sat May 26, 2018 11:16 AM	Sat May 26, 2018 11:37 AM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Martinez, Cortney	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Kostick, Richard, DO	May 26, 2018

Study Result

Generated on 7/3/19 12:55 PM



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Imaging Information (continued)**Study Result (continued)**

Procedure(s): US PELVIC COMPLETE WITH DOPPLER

Date of service: 5/26/2018 11:16 AM

Provided clinical information: 41 years, Female, "Right lower quadrant pain with large right ovarian cyst noted on CT scan"

Procedure and materials: Standard protocol.

Comparison studies: None.

Observations:

TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal

UTERUS: anteverted and smooth in configuration; Measurement: 8.3 x 4.5 x 2.9 cm and has a volumetric measurement of 56.7 cc.

ENDOMETRIAL AND VAGINAL STRIPES: The vaginal stripe is not well seen in this study. The AP diameter of the endometrial stripe is 7.5 mm. The endometrium is homogeneous in appearance.

MASSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none

MASSES OR CYSTS IN THE ADNEXA: none

RIGHT OVARY: Measurement: 4.9 x 4.1 x 5.4 cm and has a volumetric measurement of 56.8 cc. Within the right ovary is a rounded well marginated anechoic structure with through transmission measuring 3.3 x 3.3 x 4.05 cm.. Blood flow is noted within the right ovary.

LEFT OVARY: Measurement: 2.8 x 2.1 x 1.7 cm and has a volumetric measurement of 5.25 cc. Blood flow is noted within the left ovary.

FLUID IN THE CUL-DE-SAC: There is evidence of free fluid in the posterior cul-de-sac.

OTHER: none

IMPRESSION

IMPRESSION:

Large but otherwise relatively simple cyst in the right ovary measuring 3.3 x 3.3 x 4.05 cm

Free fluid is seen in the posterior cul-de-sac

These findings are unchanged from the CT scan performed earlier today

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Kostick, DO on 5/26/2018 11:50 AM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/26/2018, D/C: 5/26/2018

Imaging Information (continued)

Questionnaire (continued)

GHS TIME OUT NON-INVASIVE

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

End Exam

RIS END ALL

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH US ROOM 1 [600037]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

**MAMMO SCREENING TOMOSYNTHESIS
BILATERAL (Accession 5358520) (Order
143349308)**

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
MAMMO SCREENING TOMOSYNTHESIS BILATERAL	Final	Mon Jun 25, 2018 11:42 AM	Mon Jun 25, 2018 11:58 AM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Wells, Mary	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Ramadan, Shereef A, MD	Jun 25, 2018

Study Result

Generated on 7/3/19 12:56 PM



Imaging Results 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 6/25/2018, D/C: 6/25/2018

Imaging Information (continued)**Study Result (continued)**

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Date of service: 6/25/2018 11:42 AM

Provided clinical information: 41 years, Female, "Routine".

Procedure and materials: Bilateral 2D digital mammography and 3D Digital Breast Tomosynthesis in CC and MLO projections were obtained. 2D images were analyzed by a CAD system.

Comparison studies: Prior mammograms dated 6/5/2017, 11/30/2016 and 11/21/2016.

Most recent clinical breast exam: May 2018.

Observations:

Breast composition: There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: Stable asymmetries in both breasts.

Other pertinent findings: None.

IMPRESSION

Impression: Benign findings. No mammographic evidence of malignancy.

BI-RADS Assessment Category: Category 2: Benign.

Management Recommendation: Routine annual screening mammography per ACR and SBI guidelines.

Urgency: Routine. This is a routine medical imaging report.

Signed by Shereef Ramadan on 6/25/2018 2:00 PM

Questionnaire**Order Entry**

Question	Answer	Comment
1. Indication for Study	Routine	
2. When was the patient's last Clinical Breast Exam?		
3. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

RIS BEGIN MAMMO

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Is the patient having any breast problems?	NO - ROUTINE	



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/25/2018, D/C: 6/25/2018

Imaging Information (continued)

Questionnaire (continued)

	MAMMOGRAM
3. Please Explain	
4. Does the patient have implants?	No
5. Type of implant?	
6. Implant Location	
7. Do you perform a monthly breast self-exam?	Yes

GHS RIS HEREDITARY CANCER SYNDROME QUESTIONNAIRE

Question	Answer	Comment
1. Do you have a first degree relative (mother, sister, or daughter) or TWO second degree (grandmother, aunt, or cousin) with breast cancer?		
2. Have you had a prior breast biopsy showing atypical cells (atypical hyperplasia or lobular carcinoma in situ)?		
3. Are you or your family Ashkenazi Jewish AND if so, have any of the relatives listed below been diagnosed with breast cancer?		
4. Have you or any of the family members listed below been diagnosed with breast cancer at 50 years of age or younger?		
5. Have you or any of the family members listed below had two separate diagnoses of breast cancer or breast cancer in both breasts?		
6. Have you or any of the family members listed below been diagnosed with three or more breast cancers all on the same side of the family (all on father's or all on mother's side)?		
7. Have you or any of the family members listed below been diagnosed with a triple negative breast cancer at 60 years of age or younger? (If unsure, please choose "No")		
8. Have you or any of the family members listed below been diagnosed with male breast cancer at any age?		
9. Have you or any of the family members listed below been diagnosed with ovarian cancer at any age?		
10. Have you had chest radiation for Hodgkins Lymphoma or chest radiation for another cancer before age 30?		

End Exam

GHS RIS CLINICAL BREAST EXAM

Question	Answer	Comment
1. When was the patient's last clinical breast exam?	5-2018	
2. Waiting for outside films?	No	

RIS END ALL



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/25/2018, D/C: 6/25/2018

Imaging Information (continued)

Questionnaire (continued)

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH MAMMO ROOM 1 [600032]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

XR KNEE 4 OR MORE VIEWS RIGHT
(STANDARD) (Accession 5452126) (Order
144400432)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)	Final	Fri Jul 6, 2018 12:25 PM	Fri Jul 6, 2018 12:42 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Henson, Connie, RT	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Ballard, Luke, MD	Jul 10, 2018

Study Result

Procedure(s): XR KNEE 4 OR MORE VIEWS RIGHT (STANDARD)
Date of service: 7/6/2018 12:25 PM

Provided clinical information: 41 years, Female, "right knee pain"
Procedure and materials: Standard protocol.
Comparison studies: 3/22/2018
Observations:

Side: 4 views of the right knee.



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 7/6/2018, D/C: 7/6/2018

Imaging Information (continued)**Study Result (continued)**

Bones: Intact with no displaced fracture or focal osseous destruction.

Joints: There is anatomic alignment with normal joint spaces.

Soft tissues: Unremarkable.

IMPRESSION

Impression:

No acute osseous or articular abnormality evident. Negative knee.

Signed by Luke Ballard on 7/10/2018 2:56 AM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY:Actual Date of Procedure		
2. Views Requested	AP ERECT 0 AND 20,LAT,MERCHANT	
3. Indication for Study	right knee pain	

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	ID Band (Name & DOB) Verification Only	

GHS PREGNANCY

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Comments:		

End Exam**RIS END ALL**

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:		
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		

GHS SHIELDED

Question	Answer	Comment
1. Patient shielded?	Yes	

Patient Demographics



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/8/2018, D/C: 8/8/2018

Imaging Information (continued)

Patient Demographics (continued)

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

XR FINGER OR FINGERS MIN 2 VIEWS
RIGHT (STANDARD) (Accession 5484761)
(Order 145420916)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD)	Final	Wed Aug 8, 2018 9:50 AM	Wed Aug 8, 2018 10:04 AM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Henson, Connie, RT	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Skeist, Barry, MD	Aug 10, 2018

Study Result

Procedure(s): XR FINGER OR FINGERS MIN 2 VIEWS RIGHT (STANDARD)
Date of service: 8/8/2018 9:50 AM

Provided clinical information: 41 years, Female, "pain"

Procedure and materials: Standard protocol.

Comparison studies: 10/7/2014

Observations:

3 views of right thumb show bones to be intact. Bony relationships are normal. No erosions or calcifications or foreign bodies. Mineralization is normal.

IMPRESSION

IMPRESSION:

Normal right thumb.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Barry Skeist, MD on 8/10/2018 3:37 PM



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/8/2018, D/C: 8/8/2018

Imaging Information (continued)

Questionnaire

Order Entry

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		
2. Enter finger(s) to be radiographed	1ST-THUMB	
3. Indication for Study	pain	

Begin Exam

GHS TIME OUT NON-INVASIVE

Question	Answer	Comment
1. Patient Verification?	ID Band (Name & DOB) Verification Only	

GHS PREGNANCY

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Comments:		

End Exam

RIS END ALL

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH XR SAT ROOM 4 [600031]	
3. Was this sent to after hours reading service (VRC-Nighthawk)?		
4. Did you utilize a nurse for this exam?		

GHS SHIELDED

Question	Answer	Comment
1. Patient shielded?	Yes	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/13/2018, D/C: 8/13/2018

Imaging Information (continued)

Results

US PELVIC COMPLETE WITH EV PROBE
(Accession 5418529) (Order 145420920)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
US PELVIC COMPLETE WITH EV PROBE	Final	Mon Aug 13, 2018 11:47 AM	Mon Aug 13, 2018 12:49 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Gatlin, Rebecca	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Hubball, Ronald V, MD	Aug 16, 2018

Study Result

Procedure(s): US PELVIC COMPLETE WITH EV PROBE
Date of service: 8/13/2018 11:47 AM

Provided clinical information: 41 years, Female, "Adnexal mass, US simple cyst, follow up"
Procedure and materials: Greyscale and color doppler images obtained.
Comparison studies: May 26, 2018
Observations:
TRANSABDOMINAL AND/OR TRANSVAGINAL: transabdominal and transvaginal

UTERUS: anteverted and smooth in configuration; Measurement: 6.8 x 3.2 x 4.2 cm.

MASSES, CYSTS OR CALCIFICATIONS IN THE UTERUS: none

ENDOMETRIAL STRIPE: 8 mm. Within normal limits.

RIGHT OVARY: Measurement: 3.8 x 2.4 x 3.1 cm. Blood flow is noted within the right ovary. Prior right ovarian cyst has resolved.

LEFT OVARY: Measurement: 4.1 x 3.5 x 2.2 cm. Blood flow is noted within the left ovary. 1.6 cm simple cyst involving the left ovary. This within normal limits for patient menstrual age. There is a 2.6 cm endometrioma is present involving the left ovary. Follow-up in 12 weeks recommended. MASSES OR CYSTS IN THE ADNEXA: none

FLUID IN THE CUL-DE-SAC: none

OTHER: none

IMPRESSION
IMPRESSION:

There is an endometrioma involving the left ovary. This is new as compared back to prior examination. Follow-up in 12 weeks needed. (SRU 2009)

Urgency: Routine. This is a routine medical imaging report.



Imaging Results

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/13/2018, D/C: 8/13/2018

Imaging Information (continued)**Study Result (continued)**

Recommendation: No specific imaging recommendation.

Signed by Ronald V Hublall, MD, FRCPC, FACR on 8/16/2018 4:32 PM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

End Exam**RIS END ULTRASOUND EV**

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH US ROOM 1 [600037]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		
5. RIS Ultrasound Transducer	RPH 1 - B1ZPNC	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results**XR FOOT MIN 3 VIEWS LEFT (STANDARD)**
(Accession 5499892) (Order 146848612)**Imaging Information**



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/23/2018, D/C: 8/23/2018

Imaging Information (continued)**Exam Information**

Performed Procedure	Study Status	Begin Time	End Time
XR FOOT MIN 3 VIEWS LEFT (STANDARD)	Final	Thu Aug 23, 2018 11:49 AM	Thu Aug 23, 2018 12:00 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Ferrier, Canli	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Gaur, Sarel, MD	Aug 24, 2018

Study Result

Procedure(s): XR FOOT MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/23/2018 11:49 AM

Provided clinical information: 41 years, Female, "left foot pain"

Procedure and materials: Standard protocol.

Side: Left

Comparison studies: October 28, 2016

IMPRESSION

Observations and Impression:

There is no acute fracture or dislocation. Mineralization is preserved. The soft tissues are unremarkable.

Recommendation: No specific imaging recommendation.

Thank you for this kind referral,

SAREL GAUR MD | Diagnostic and Interventional Radiologist
c 570.423.2146

Signed by Sarel Gaur on 8/24/2018 5:16 PM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		
2. Indication for Study	left foot pain	erect AP Lateral (include foot and ankle) oblique

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

GHS PREGNANCY



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/23/2018, D/C: 8/23/2018

Imaging Information (continued)

Questionnaire (continued)

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Comments:		

End Exam

RIS END ALL

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?	FERRIER, CANLI [CFERRIER]	
2. Confirm Resource:		
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		

GHS SHIELDED

Question	Answer	Comment
1. Patient shielded?	Yes	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

XR SHOULDER MIN 2 VIEWS LEFT
(STANDARD) (Accession 5531398) (Order
148258605)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)	Final	Mon Sep 24, 2018 1:34 PM	Mon Sep 24, 2018 1:48 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
O'Dea, Kelly, RT	N/A	N/A	N/A

Verification Information



Imaging Results 1 4 1 9 0 7 1 2 0 0 0 0 3 0 3
Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 9/24/2018, D/C: 9/24/2018

Imaging Information (continued)**Verification Information (continued)**

Signed By
Ballard, Luke, MD

Signed On
Sep 26, 2018

Study Result

Procedure(s): XR SHOULDER MIN 2 VIEWS LEFT (STANDARD)
Date of service: 9/24/2018 1:34 PM

Provided clinical information: 41 years, Female, "pain"
Procedure and materials: 3 view left shoulder.
Comparison studies: 3/22/2018.
Observations:

Bones: Intact with no displaced fracture or focal osseous destruction.
Joints: There is anatomic alignment of the glenohumeral and
acromioclavicular joints with normal joint spaces.
Soft tissues: Unremarkable.

IMPRESSION

Impression:
No acute osseous or articular abnormality evident.

Signed by Luke Ballard on 9/26/2018 10:27 AM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		
2. Views Requested	AP, Y, AXILLARY	
3. Indication for Study	pain	

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

GHS PREGNANCY

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Comments:		

End Exam**RIS END ALL**

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?	O'DEA, KELLY [KODEA]	
2. Confirm Resource:	RPH XR SAT ROOM 1 [600028]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/24/2018, D/C: 9/24/2018

Imaging Information (continued)

Questionnaire (continued)

4. Did you utilize a nurse for this exam?

GHS SHIELDED

Question	Answer	Comment
1. Patient shielded?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

US PELVIC COMPLETE WITH EV PROBE
(Accession 5521640) (Order 149957031)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
US PELVIC COMPLETE WITH EV PROBE	Final	Thu Nov 8, 2018 11:05 AM	Thu Nov 8, 2018 11:41 AM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Martinez, Cortney	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Dyer, Patrick, MD	Nov 14, 2018

Study Result

Procedure(s): US PELVIC COMPLETE WITH EV PROBE

Date of service: 11/8/2018 11:05 AM

History: 42 years, Female, "Follow up endometrioma left ovary"

Technique: A transabdominal and transvaginal sonogram of the pelvis was performed using color and grayscale technique.

Findings:



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/8/2018, D/C: 11/8/2018

Imaging Information (continued)**Study Result (continued)**

Uterus: The uterus demonstrates normal parenchymal echotexture and echogenicity. The endometrial-myometrial junction is well-maintained. The uterus measures 7.2 x 2.9 x 3.8 cm.

Endometrium: There are tiny anechoic cysts within the endometrium. The endometrium is not thickened (Time stamp 11: 21: 18, A.M.). Small minimally complicated nabothian cysts are seen along the cervix. The lower uterine segment is otherwise within normal limits. The endometrium measures 8 mm when measured accurately.

Ovaries: There is a 2.0 cm circumscribed right ovarian cyst containing thickened internal septations and a nodular echogenic component along its anterolateral border, new since prior examination. There is a 1.8 x 1.7 cm x 2.0 circumscribed, homogeneously echogenic left renal lesion, previously measuring 2.1 cm. (Time stamp 11: 27: 11, A.M.).

Spectral interrogation of the ovaries was not performed.

The right ovary measures 4.6 x 2.1 x 2.8 cm.

The left ovary measures 3.6 x 2.8 x 2.0 cm.

Adnexa: There are no adnexal masses or significant free fluid.

IMPRESSION**IMPRESSION:**

There is a minimally complex right ovarian cystic lesion favoring an evolving hemorrhagic cyst.

Size stable echogenic lesion of the left ovary. An MRI of the pelvis with and without intravenous contrast could be acquired to exclude an endometrioma if warranted.

Additionally, there is apparent cystic change within the nonthickened endometrium. Possibly representing a focus of evolving cystic endometrial hyperplasia. Tissue sampling could be acquired for further characterization and to exclude other less common etiologies. Otherwise, attention at routine imaging follow-up is requested.

Signed by Patrick Dyer, MD on 11/14/2018 3:45 AM

Questionnaire**Order Entry****Question****Answer****Comment**

1. RAD FILE ROOM USE ONLY: Actual Date of Procedure

Begin Exam**GHS TIME OUT NON-INVASIVE****Question****Answer****Comment**

1. Patient Verification?

Verbal & ID band (Name & DOB) Verification

End Exam**RIS END ULTRASOUND EV**



Imaging Results

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 11/8/2018, D/C: 11/8/2018

Imaging Information (continued)

Questionnaire (continued)

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH US ROOM 1 [600037]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		
5. RIS Ultrasound Transducer	RPH 1 - B1ZPNC	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

MR PELVIS W AND WO CONTRAST
(Accession 5594453) (Order 150855778)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
MR PELVIS WITH AND WITHOUT CONTRAST	Final	Thu Dec 13, 2018 6:38 PM	Thu Dec 13, 2018 7:45 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Rosenberger, Brian S	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Gaur, Sarel, MD	Dec 23, 2018

Study Result

PROCEDURE(S): MR PELVIS W AND WO CONTRAST
(Contrast Enhanced MR of the Pelvis)

DATE OF SERVICE: 12/13/2018 6:38 PM

PROVIDED CLINICAL INFORMATION: 42 years, Female, "Adnexal mass, US complex or solid mass, follow up: rule out endometrioma"



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 12/13/2018, D/C: 12/13/2018

Imaging Information (continued)**Study Result (continued)**

PROCEDURE AND MATERIALS: Standard protocol. (multiplanar multisequence MR imaging of the pelvis was obtained)

CONTRAST: IV contrast only.

COMPARISON STUDIES: Ultrasound dated November 8, 2018 and report from August 13, 2018

OBSERVATIONS:

VESSELS: Normal caliber aorta.

REPRODUCTIVE ORGANS: Several cysts are seen involving both ovaries, more prominent involving the right ovary. There is a 23 mm right ovarian peripherally hyperenhancing cyst most compatible with a corpus luteal cyst.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: No aggressive lesions.

ABDOMINAL WALL: Unremarkable.

IMPRESSION**IMPRESSION:**

Follicles are seen involving both ovaries, within normal limits for a patient of reproductive age. Of note there is a 23 mm right ovarian corpus luteal cyst. There is no definitive MR evidence for a endometrioma involving the left ovary, as previously suggested on ultrasound.

RECOMMENDATION:

No specific imaging recommendation.

Thank you for this kind referral,

SAREL GAUR MD | Diagnostic and Interventional Radiologist
c 570.423.2146

Signed by Sarel Gaur on 12/23/2018 2:44 PM

Scans on Order 150855778

Scan on 12/14/2018 7:58 AM by Massage, Victoria: MRI SAFETY SHEET

Questionnaire**Order Entry**

Question	Answer	Comment
1. Does the patient have a pacemaker or defibrillator?	No	
2. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam**GHS TIME OUT NON-INVASIVE**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 12/13/2018, D/C: 12/13/2018

Imaging Information (continued)

Questionnaire (continued)

GHS MRI SAFETY SHEET

Question	Answer	Comment
1. Has technologist completed MRI safety sheet?	Yes	

End Exam

RIS END CONTRAST

Question	Answer	Comment
1. Type of contrast administered:		
2. Contrast amount (mL)?		
3. Who administered the contrast?		
4. Contrast expiration date?	6/30/2023	
5. Contrast lot#?	82588B	
6. Injection Site	Wrist	right side
7. Was contrast type and amount verified in the charges section above?		
8. Confirm Resource:	RPH MR ROOM 1 [600035]	
9. Was this sent to after hours reading service (VRC-Nighthawk)		
10. Did you utilize a nurse for this exam?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

XR ELBOW 2 VIEWS RIGHT (Accession
5669580) (Order 154399047)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
XR ELBOW 2 VIEWS RIGHT	Final	Thu Feb 7, 2019 3:36 PM	Thu Feb 7, 2019 3:41 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Burdick, Torie L	N/A	N/A	N/A



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/7/2019, D/C: 2/7/2019

Imaging Information (continued)

Staff Information (continued)

Verification Information

Signed By
Stuelke, Satre, MDSigned On
Feb 11, 2019

Study Result

Procedure(s): XR ELBOW 2 VIEWS RIGHT

Date of service: 2/7/2019 3:36 PM

Provided clinical information: 42 years, Female, "pain"

Procedure and materials: 2 images of the right elbow were obtained.

Comparison studies: None.

Observations:

No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.

IMPRESSION

Impression:

Unremarkable exam.

Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM

Questionnaire

Order Entry

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		
2. Indication for Study	pain	

Begin Exam

GHS TIME OUT NON-INVASIVE

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

GHS PREGNANCY

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Comments:		

End Exam

RIS END ALL

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH XR SAT ROOM 2 [600029]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/7/2019, D/C: 2/7/2019

Imaging Information (continued)

Questionnaire (continued)

GHS SHIELDED

Question	Answer	Comment
1. Patient shielded?	Yes	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

CT HEAD WITHOUT IV CONTRAST
(Accession 5745877) (Order 157252875)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
CT HEAD WITHOUT IV CONTRAST	Final	Thu Apr 18, 2019 3:29 PM	Thu Apr 18, 2019 3:45 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Kopatz, Carolyn, RT	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Zwirko, Richard, MD	Apr 18, 2019

Study Result

Procedure(s): CT HEAD WITHOUT IV CONTRAST
Date of service: 4/18/2019 3:29 PM

Provided clinical information: 42 years, Female, "Headache, acute,
norm neuro exam: sent by family practice for CT"
Procedure and materials: Standard protocol.
Contrast: None.

Comparison studies: 7/17/2008.

Observations:

There is no midline shift or mass effect. CSF spaces appear normal for
age. No pathologic fluid collections are seen. No acute intracranial
hemorrhage is noted.



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

Imaging Information (continued)**Study Result (continued)**

The gray-white matter differentiation is well preserved. There is no evidence for an acute transcortical or vascular territorial infarct.

There is no depressed calvarial fracture. The skull base and surrounding soft tissues appear unremarkable.

IMPRESSION**IMPRESSION:**

No acute intracranial findings.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM

Questionnaire**Order Entry**

Question	Answer	Comment
1. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam**GHS TIME OUT CT**

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	
2. Is the patient pregnant?	No	
3. Comments:		
4. When was your LMP?		

End Exam**RIS END ALL**

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH CT ROOM 1 [600021]	
3. Was this sent to after hours reading service (VRC-Nighthawk)		
4. Did you utilize a nurse for this exam?		

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/21/2019, D/C: 6/21/2019

Imaging Information (continued)**Patient Demographics (continued)**

Reg Status	PCP
Verified	Gillan, Michael F, DO570-887-2239

Results
MR ABDOMEN PELVIS ENTEROGRAPHY
(Accession 5793159) (Order 159007929)
Imaging Information**Exam Information**

Performed Procedure	Study Status	Begin Time	End Time
MR ABDOMEN PELVIS ENTEROGRAPHY	Final	Fri Jun 21, 2019 12:04 PM	Fri Jun 21, 2019 1:40 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Smith, Casey, RT	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Bennett, Christopher J, MD	Jun 27, 2019

Study Result

Procedure: MR ABDOMEN PELVIS ENTEROGRAPHY.
 Date of Service: 6/21/2019 12:04 PM.
 Relevant Clinical Information: Abdominal pain, unspecified: Crohn dz,
 known, increasing abd pain or fever or leukocytosis.
 Procedure and Materials: MR enterography
 Comparison Studies: 10 mL Gadavist IV

Observations:

The small bowel and colon are normal in caliber. No mural thickening or hyperenhancement is identified to indicate active enteritis. No stricture or fistulization is apparent. No organized abscess is identified.

Visualized portions of the liver, spleen, kidneys and pancreas are unremarkable. The patient is status post cholecystectomy, without biliary ductal dilation.

IMPRESSION

No evidence of active enteritis, stricture, fistulization or abscess.

Signed by Christopher Bennett, MD on 6/27/2019 11:43 AM

Scans on Order 159007929

Scan on 6/21/2019 7:16 PM by Grosser, Kathleen: Radiology safety form-MRI Sheet

Scan on 6/21/2019 7:16 PM by Grosser, Kathleen: Radiology Contrast



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/21/2019, D/C: 6/21/2019

Imaging Information (continued)

Questionnaire

Order Entry

Question	Answer	Comment
1. Does the patient have a pacemaker or defibrillator?	No	
2. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam

GHS TIME OUT NON-INVASIVE

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

GHS MRI SAFETY SHEET

Question	Answer	Comment
1. Has technologist completed MRI safety sheet?	Yes	

End Exam

RIS END CONTRAST

Question	Answer	Comment
1. Type of contrast administered:		
2. Contrast amount (mL)?		
3. Who administered the contrast?		
4. Contrast expiration date?	10/23/2023	
5. Contrast lot#?	KT029B7	
6. Injection Site	Antecubital	Rt
7. Was contrast type and amount verified in the charges section above?		
8. Confirm Resource:	RPH (OPEN) MOBILE MR [600036]	
9. Was this sent to after hours reading service (VRC-Nighthawk)		
10. Did you utilize a nurse for this exam?	Yes	

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/26/2019, D/C: 6/26/2019

Imaging Information (continued)

Results

**MAMMO SCREENING TOMOSYNTHESIS
BILATERAL (Accession 5808345) (Order
159007935)**

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
MAMMO SCREENING TOMOSYNTHESIS BILATERAL	Final	Wed Jun 26, 2019 4:39 PM	Wed Jun 26, 2019 4:41 PM

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
Wells, Mary	N/A	N/A	N/A

Verification Information

Signed By	Signed On
Werner, Elizabeth, MD	Jun 27, 2019

Study Result

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL
Date of service: 6/26/2019 4:39 PM

Provided clinical information: 42-year-old asymptomatic female for screening mammogram

Procedure and materials: Bilateral 2-D digital mammography and 3-D digital breast tomosynthesis in CC and MLO projections were obtained. 2-D images were analyzed by a CAD system.
Comparison studies: 1/25/18, 6/5/17, 11/21/16.
Most recent clinical breast exam: A year ago.

Observations:

Breast composition: b. There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: None.

Other pertinent findings: None.

IMPRESSION

Negative. No mammographic evidence of malignancy.
Recommend annual screening mammogram.

BI-RADS Assessment: Category 1: Negative

Management Recommendation: Routine annual screening mammography.

Signed by Elizabeth Werner, MD on 6/27/2019 10:16 AM

Questionnaire

Order Entry



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/26/2019, D/C: 6/26/2019

Imaging Information (continued)

Questionnaire (continued)

Question	Answer	Comment
1. Indication for Study	annual	
2. When was the patient's last Clinical Breast Exam?		
3. RAD FILE ROOM USE ONLY: Actual Date of Procedure		

Begin Exam

GHS TIME OUT NON-INVASIVE

Question	Answer	Comment
1. Patient Verification?	Verbal & ID band (Name & DOB) Verification	

RIS BEGIN MAMMO

Question	Answer	Comment
1. Is the patient pregnant?	No	
2. Is the patient having any breast problems?	NO - ROUTINE MAMMOGRAM	
3. Please Explain		
4. Does the patient have implants?	No	
5. Type of implant?		
6. Implant Location		
7. Do you perform a monthly breast self-exam?	Yes	

GHS RIS HEREDITARY CANCER SYNDROME QUESTIONNAIRE

Question	Answer	Comment
1. Do you have a first degree relative (mother, sister, or daughter) or TWO second degree (grandmother, aunt, or cousin) with breast cancer?		
2. Have you had a prior breast biopsy showing atypical cells (atypical hyperplasia or lobular carcinoma in situ)?		
3. Are you or your family Ashkenazi Jewish AND if so, have any of the relatives listed below been diagnosed with breast cancer?		
4. Have you or any of the family members listed below been diagnosed with breast cancer at 50 years of age or younger?		
5. Have you or any of the family members listed below had two separate diagnoses of breast cancer or breast cancer in both breasts?		
6. Have you or any of the family members listed below been diagnosed with three or more breast cancers all on the same side of the family (all on father's or all on mother's side)?		
7. Have you or any of the family members listed below been diagnosed with a triple negative breast cancer at 60 years of age or younger? (If unsure, please choose "No")		
8. Have you or any of the family members listed		



Imaging Results

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/26/2019, D/C: 6/26/2019

Imaging Information (continued)

Questionnaire (continued)

below been diagnosed with male breast cancer at any age?

9. Have you or any of the family members listed below been diagnosed with ovarian cancer at any age?

10. Have you had chest radiation for Hodgkins Lymphoma or chest radiation for another cancer before age 30?

End Exam

GHS RIS CLINICAL BREAST EXAM

Question	Answer	Comment
1. When was the patient's last clinical breast exam?	x1 yr ago	
2. Waiting for outside films?	No	

RIS END ALL

Question	Answer	Comment
1. Who verified the patient's identity and procedural site?		
2. Confirm Resource:	RPH MAMMO ROOM 1 [600032]	
3. Was this sent to after hours reading service (VRC-Nighthawk)?		
4. Did you utilize a nurse for this exam?		

**GUTHRIE**

Procedure/Operative Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.co m	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

COLONOSCOPY REPORT [143345468]

Electronically signed by: Interface, Multispeciality Results on 06/11/18 0737

Status: Completed

Ordering user: Interface, Multispeciality Results 06/11/18 0737 Ordering provider: Gillan, Michael F, DO

Authorized by: Gillan, Michael F, DO

Frequency: One Time 06/11/18 0740 - 1 occurrence

Results**COLONOSCOPY REPORT (Order 143345469)****Electronically Signed by:** McDonald, Thomas J, MD on 6/11/2018 8:45 AM**COLONOSCOPY REPORT [143345469]**

Resulted: 06/11/18 0845, Result status: Final result

Ordering provider: Gillan, Michael F, DO 06/11/18 0737

Resulted by: McDonald, Thomas J, MD

Filed by: Interface, Multispeciality Results 06/11/18 0845

Resulting lab: PROVATION

Acknowledged by: Gillan, Michael F, DO on 06/11/18 1027

Specimen Information

Type	Source	Collected On
—	—	06/11/18 0737

Components

Component	Value	Reference Range	Flag	Lab
GI Procedure	—	—	—	PROV

Result:
Robert Packer Hospital

Patient Name: Jennifer Lyn Brown	Procedure Date: 6/11/2018 7:37 AM
MRN: 340616	Account Number: 69394950
Date of Birth: 10/26/1976	Admit Type: Outpatient
Age: 41	Room: 17
Gender: Female	Note Status: Finalized
Attending MD: THOMAS J MCDONALD JR , MD	Instrument Name: 4092 CF-H180AL

Procedure:	Colonoscopy
Indications:	Personal history of Crohn's disease
Providers:	THOMAS J. MCDONALD JR, MD, Sherri Weston, RN (Nurse), Jennifer Donovan (Nurse)
Referring MD:	MICHAEL F. GILLAN, DO (Referring MD)
Medicines:	See the Anesthesia note for documentation of the administered medications
Complications:	No immediate complications.

Procedure:	The patient's current medications and allergies were reviewed and recorded in the nurses notes. The patient was made aware of the risk of the procedure which can include:
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Procedure/Operative
Report

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Imaging Information (continued)

bleeding, infection, perforation, an adverse reaction to sedation, and a risk of missed lesions, among others. The patient appeared to understand. An opportunity for questions was provided, and an informed consent form was signed. The scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse EKG, and oxygen saturations were monitored continuously. The Colonoscope was introduced through the anus and advanced to the cecum, identified by appendiceal orifice and ileocecal valve. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.

Findings:

The terminal ileum appeared normal.

The colon (entire examined portion) appeared normal. Biopsies were taken with a cold forceps for histology.

Impression:

- The examined portion of the ileum was normal.
- The entire examined colon is normal. Biopsied.

Recommendation:

- Continue present medications.
- Await pathology results.
- Repeat colonoscopy in 3 years for surveillance.
- Return sooner if symptoms occur. Polyps can be missed.
- Discharge patient to home.

Procedure Code(s): --- Professional ---

45380, Colonoscopy, flexible; with biopsy, single or multiple

Diagnosis Code(s): --- Professional ---

Z87.19, Personal history of other diseases of the digestive system

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The codes documented in this report are preliminary and upon coder review may be revised to meet current compliance requirements.

THOMAS J MCDONALD JR, MD

6/11/2018 8:45:29 AM

This report has been signed electronically.

Number of Addenda: 0

Note Initiated On: 6/11/2018 7:37 AM

CC Letter to: MICHAEL F. GILLAN, DO (CC)

View Image (below)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
53 - PROV	PROVATION	Unknown	Unknown	01/23/13 0830 - Present

Collection Information

Specimen ID: 550421

**GUTHRIE**Procedure/Operative
Report

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Imaging Information (continued)**Collection Information (continued)**

Collected: 6/11/2018 7:37 AM

Resulting
Agency:

PROVATION

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.co m	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

UPPER GI ENDOSCOPY REPORT [143345466]

Electronically signed by: Interface, Multispecialty Results on 06/11/18 0738

Status: Completed

Ordering user: Interface, Multispecialty Results 06/11/18 0738

Ordering provider: Gillan, Michael F, DO

Authorized by: Gillan, Michael F, DO

Frequency: One Time 06/11/18 0740 - 1 occurrence

Results**UPPER GI ENDOSCOPY REPORT (Order
143345467)****Electronically Signed by: McDonald, Thomas J, MD on 6/11/2018 8:23 AM****UPPER GI ENDOSCOPY REPORT [143345467]**

Resulted: 06/11/18 0823, Result status: Final result

Ordering provider: Gillan, Michael F, DO 06/11/18 0738

Resulted by: McDonald, Thomas J, MD

Filed by: Interface, Multispecialty Results 06/11/18 0823

Resulting lab: PROVATION

Acknowledged by: Gillan, Michael F, DO on 06/11/18 1027

Specimen Information

Type	Source	Collected On
—	—	06/11/18 0738

Components

Component	Value	Reference Range	Flag	Lab
Upper GI endoscopy	—	—	—	PROV
Result:				
Robert Packer Hospital				

Patient Name: Jennifer Lyn Brown	Procedure Date: 6/11/2018 7:38 AM
MRN: 340616	Account Number: 69394950
Date of Birth: 10/26/1976	Admit Type: Outpatient
Age: 41	Room: 17
Gender: Female	Note Status: Finalized
Attending MD: THOMAS J MCDONALD JR , MD	Instrument Name: 1106 GIF H180J

Procedure:	Upper GI endoscopy
Indications:	Functional Dyspepsia
Providers:	THOMAS J. MCDONALD JR, MD
Referring MD:	MICHAEL F. GILLAN, DO (Referring MD)
Medicines:	See the Anesthesia note for documentation of the

**GUTHRIE**

Procedure/Operative Report

141907120000303

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Imaging Information (continued)

administered medications
 Complications: No immediate complications.

Procedure: The patient's current medications and allergies were reviewed and recorded in the nurses notes. The patient was made aware of the risk of the procedure which can include: bleeding, infection, perforation, an adverse reaction to sedation, and a risk of missed lesions, among others. The patient appeared to understand. An opportunity for questions was provided, and an informed consent form was signed. The scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse EKG, and oxygen saturations were monitored continuously. The Endoscope was introduced through the mouth, and advanced to the second part of duodenum. The Z-line was located at:
 The upper GI endoscopy was accomplished without difficulty. The patient tolerated the procedure well.

Findings:

The esophagus was normal.
 Diffuse mildly erythematous mucosa without bleeding was found in the gastric antrum. Biopsies were taken with a cold forceps for histology.
 The examined duodenum was normal.

Impression: - Normal esophagus.
 - Erythematous mucosa in the antrum. Biopsied.
 - Normal examined duodenum.
 Recommendation: - Continue present medications.
 - Await pathology results.
 - Discharge patient to home.

Procedure Code(s): --- Professional ---
 43239, 51, Esophagogastroduodenoscopy, flexible,
 transoral; with biopsy, single or multiple

Diagnosis Code(s): --- Professional ---
 K31.89, Other diseases of stomach and duodenum

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The codes documented in this report are preliminary and upon coder review may be revised to meet current compliance requirements.

THOMAS J MCDONALD JR, MD

6/11/2018 8:22:52 AM

This report has been signed electronically.

Number of Addenda: 0

Note Initiated On: 6/11/2018 7:38 AM

CC Letter to: MICHAEL F. GILLAN, DO (CC)

View Image (below)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
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**GUTHRIE**Procedure/Operative
Report

1 4 1 9 0 7 1 2 0 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/11/2018, D/C: 6/11/2018

Imaging Information (continued)

53 - PROV

PROVATION

Unknown

Unknown

01/23/13 0830 - Present

Collection Information

Specimen ID: 550422

Collected: 6/11/2018 7:38 AM

Resulting
Agency:

PROVATION

**GUTHRIE**Procedure/Operative
Report

141907120000303

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 5/24/2019, D/C: 5/24/2019**Patient Demographics**

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.co m	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Results

(Order)

Electronically Signed by:**Op Note by Choi, Joseph, MD at 5/24/2019 9:25 AM**

Author: Choi, Joseph, MD	Service: ORTHOPEDIC	Author Type: Physician
Filed: 5/24/2019 9:30 AM	Date of Service: 5/24/2019 9:25 AM	Creation Time: 5/24/2019 9:25 AM
Status: Signed	Editor: Choi, Joseph, MD (Physician)	

OPERATIVE NOTE**RPH/Guthrie Clinic
Sayre PA****Name:** Jennifer Lyn Brown**MRN:** 340616**DOB:** 10/26/1976**Date of procedure:** 5/24/19**Preoperative diagnosis:**

1. Impingement syndrome and acromioclavicular joint arthritis-left

Postoperative diagnosis: Same**Procedure:**

1. Arthroscopic subacromial decompression with acromioplasty and distal clavicle excision-left

Attending: Joseph Choi, MD, PhD**Assistant:** Nick Marsiglio, PA. Due to the complicated nature of this case an assistant was necessary. His/her help was invaluable to the completion of this case.**Implants:**



GUTHRIE

Procedure/Operative
Report

1 4 1 9 0 7 1 2 0 0 0 3 0 3

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

Imaging Information (continued)

Op Note by Choi, Joseph, MD at 5/24/2019 9:25 AM (continued)

None

Tubes/Drains: none**Estimated Blood Loss:** minimal**Antibiotics:** See records**Anesthesia:**

1. General endotracheal anesthesia
2. Interscalene block

Complications: none**Sponge and needle counts:** correct**Indications for procedure:**

Having failed conservative care, this patient opted for operative intervention. The risks and benefits are discussed in my pre operative history and physical. Informed consent was obtained. Medical clearance was obtained if necessary.

Procedure:

The patient was identified in the waiting area. The left shoulder was marked, and the consent form and history/physical was reviewed. This was consistent with what we planned on doing. The anesthesia staff administered antibiotics and an interscalene block. Afterwards the patient was brought to the operating room where a second time out was done consistent with hospital protocol. After general anesthesia was administered, the patient was placed in a T-Max head holder in the beach chair position. All prominences were well padded. Range of motion was normal. There was no instability. After prepping and draping the shoulder, a standard posterior portal was placed and a diagnostic arthroscopy was performed. The glenoid cartilage was intact. The humeral head cartilage was intact. The biceps tendon was intact. The labrum was intact. The visualized articular portion of the rotator cuff was intact. The subscapularis was intact. An extensive intra articular debridement was not needed. After the intra articular part was completed, the camera was placed into the subacromial space and a lateral portal was established using a spinal needle as a guide. I placed the camera from the side and from the back, through a 7 mm screw-in cannula, I did a thorough subacromial decompression. Extensive bursitis was present. I also partially resected the undersurface of the coracoacromial ligament and exposed a small but prominent spur on the undersurface of the acromion. This was removed with a burr in reverse. After the acromioplasty was performed, I inspected the bursal side of the rotator cuff tendons. They were intact. No tear was present. I established an anterior portal with an aid of a spinal needle for the distal clavicle resection. Soft tissue was cleared underneath as well as in the acromioclavicular joint. Debris was removed with a shaver. Using a burr I removed lateral clavicle as well as bone from the acromial side. The distal clavicle excision was uniformed when viewed with the 70 degree as well as the 30 degree arthroscope. We had enough room in the acromioclavicular joint-approximately 8 mm of space.

**GUTHRIE**Procedure/Operative
Report

141907120000303

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 5/24/2019, D/C: 5/24/2019**Imaging Information (continued)****Op Note by Choi, Joseph, MD at 5/24/2019 9:25 AM (continued)**

There is no abutment with cross adduction testing. Afterwards, the arthroscopy was terminated, and the wounds were closed. Bulky dressing was applied and a sling was placed. The patient was brought to the recovery room in good condition.

Postoperative course:

Patient will be in a sling for comfort. Activity as tolerated. Pain medication as prescribed. My standard discharge sheet was given to the patient.

Electronically signed by Choi, Joseph, MD at 5/24/2019 9:30 AM

Collection Information**END OF REPORT**

FAX COVER SHEET

GUTHRIE MEDICAL GROUP

GASTROENTEROLOGY/HEPATOLOGY

1 GUTHRIE SQUARE

SAYRE, PA 18840

PHONE 570-887-2852

FAX 570-887-3114

TO: K. Richardson

FAX: 866-323-8335

FROM: Janine Bell

RE: J. Brown disability

PAGES INCLUDING COVER SHEET: 2

THIS IS FOR PERSONAL AND CONFIDENTIAL USE ONLY. IF YOU
DO NOT RECEIVE ALL PAGES, PLEASE NOTIFY OUR OFFICE AT
THE ABOVE TELEPHONE NUMBER. THANK YOU.

773

New York State Office of Temporary and Disability Assistance
Division of Disability Determinations

P.O. BOX 8783

LONDON, KY 40742

Phone: (518)626-3238 Toll Free: 1-800-522-5511 Ext. 3238 Fax: 1-866-323-8335

E112

July 01, 2019

In Reference to Claimant

THOMAS MCDONALD, MD
MEDICAL RECORDS
GUTHRIE SQ DEPT OF M
GASTROENTEROLOGY 3RD LEVEL
SAYRE, PA 18840-0000

SSN: 132-58-2507 DOB: 10/26/1976
Name: JENNIFER L. BROWN
14 MAIN ST LOT 429
WELLSBURG, NY 14894

MER ORDER#: F003D6B60

Please use MER ORDER# for Remittance Tracking.

This agency is responsible for the adjudication of disability claims on behalf of the federal government under the Social Security Act. Your patient has made an application for benefits and we need medical evidence from treatment sources to evaluate the claim. A written consent is enclosed for us to receive this information from you.

Social Security Regulations require us to obtain complete medical documentation of the impairment. Attached is a medical questionnaire related to your patient's medical condition, which will help you provide us with the information we need to evaluate the impairment in terms of the standards for the program. At times we need additional medical information beyond that which you supply in your report. If you would be willing to perform consultative examinations, if needed, for us of your own patients on a fee for service basis, please let us know when you respond to this letter.

You may reply directly on the questionnaire, submit a copy of your records, or provide a report on your letterhead, whichever is most convenient.

Your cooperation is appreciated.

Sincerely yours,
K. Richardson
Disability Analyst - Unit V139

****PLEASE FOLLOW INSTRUCTIONS TO RECEIVE PAYMENT****

VOUCHER INSTRUCTIONS: Billed Amount: \$10.00

We are authorized to pay for medical information which is useful and relevant. If you wish payment, please **COMPLETE ALL BOXES BELOW** or **REVIEW PREPRINTED INFORMATION**. Preprinted information needing correction must be authorized via signed correspondence on the facility letterhead and returned with this letter.

Payee ID: Enter the 9-Digit Federal ID assigned to you as an employer. If you are operating as an individual in business, enter your Social Security Number. The ID number **MUST** belong to the payee.

Payee Name: Enter your name and address **AS YOU WISH IT TO APPEAR ON THE CHECK.**

Payee ID:		Payee Certification: I certify that the above is just, true and correct and that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.
Payee Name:		
Address:		
Address:		Payee's Signature in Ink:
City, State, ZIP:		
		Title: _____ Date: _____

Off. Use Only: RO Signature/Date:

CO - Signature/Date/Interest:

PLEASE RETURN THIS LETTER WITH YOUR REPLY IN THE ENCLOSED ENVELOPE OR FAX TO THE NUMBER ABOVE

Dr McDonald has not seen this Pt in our office.

He has performed colonoscopies for her, only

** Pt sees Dr Michael Georgetown in our practice.*

6/00023164787/LEX: 9749/V139/THOMAS MCDONALD, MD

/DDD-3883

Page 1 of 6

774

EXHIBIT NO. B5F
PAGE: 1 OF 58



NYS Office of Temporary and Disability
Assistance, Division of Disability
Determinations
K. RICHARDSON
PO Box 8783
London, KY 40742-9927

TX#6020-73077

141908280000384

****Please send all available medical records including imaging, diagnostics and testing, from 06/19/2017 to present. Thank you.****

1908280000384

Patient ID Number: 340616 Date of Last Exam:

Frequency of Treatment: Date First Seen:

Height: Weight:

Blood Pressure, Most Recent, Significant Changes Noted:

Treating Diagnoses:

Please indicate current symptoms:

Treatment and Response:

Please include medications prescribed with dosage and frequency, side effects, and any surgical procedures performed:

Please indicate the expected duration and prognosis of the claimant's condition:

— If your patient has displayed any behavior suggestive of a significant psychiatric disorder, please describe (with dates): —

History and Subsequent Course:

Please include the date(s) diagnosed & earliest symptoms (e.g. chest pain, weight loss, fatigue, etc.), etiology of impairment, initial findings on physical examination, and subsequent course:

Clinical Findings:

Please describe both positive & negative findings such as any loss of motion in degrees (or estimate the %) site & severity of any neurological deficits, any organ enlargement, & other abnormalities noted.

If fatigue is present:

What are the precipitating factors or types of activities that bring on fatigue, & how soon after starting the activity does the fatigue begin?

Once the fatigue begins, how long must the patient rest before he/she can engage in activities again?

Please describe any physical or other objective signs of chronic fatigue. If depression is present, is it primary or secondary to the fatigue?

Laboratory Findings:

Please include the dates & results of all blood studies, x-rays, pulmonary function studies, & special studies. (Please send a copy of the report.) In cardiac cases, please provide copies of any abnormal EKG tracings or a representative tracing when abnormal findings are not present.

Describe any limitations of physical activity as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity; include specific symptoms and resulting limitations.

Based on the medical findings provided in my report, my medical opinion regarding this individual's ability to do work-related physical activities is as follows:

- Lift and Carry
 - ☐ No Limitation ☐ Limited (Please specify both below)
 - ☐ Occasionally (up to 1/3 of a work day): lbs.
 - ☐ Frequently (up to 2/3 of a work day): lbs.
 - Maximum number of pounds that can be lifted and carried is: lbs.
- Stand and/or Walk
 - ☐ No Limitation ☐ Limited (please check extent below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Up to 2 hours per day ☐ Less than 2 hours per day
- Sit
 - ☐ No Limitation ☐ Limited (please check one below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Less than 6 hours per day
- Push and/or Pull (including hand & foot controls)
 - ☐ No Limitation ☐ Limited (please specify below)
 - ☐ Upper extremities (please describe)
- Other (e.g. postural, manipulative, visual, communicative, environmental)
 - ☐ No Limitation ☐ Limited (please describe below)

☐ I cannot provide a medical opinion regarding this individual's ability to do work-related activities.

Are there any other conditions significant to recovery? ☐ No ☐ Yes

- If yes, please record your comments below. (If necessary, the reverse of this page may be used.)

Please indicate the best days and times for us to call if we need to ask for additional or clarifying information. Day: Time:

Facility Phone

Signature Title

Name Printed Date

Dr. Freeman does not provide disability forms - Thank you.



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 11/22/2017

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

11/22/2017 1:00 PM	Provider James Freeman	Department Sayre Rheumatology	Har	Center SAYRE
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**Office Visit
11/22/2017****Jennifer Lyn Brown
MRN: 340616****Notes****Progress Notes by Khan, Muhammad Z, MD at 11/22/2017 1:00 PM**

Author: Khan, Muhammad Z, MD	Service: —	Author Type: Resident
Filed: 12/4/2017 9:18 AM	Encounter Date: 11/22/2017	Status: Signed
Editor: Khan, Muhammad Z, MD (Resident)		

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 11/22/2017

CHIEF COMPLAINT:
 No chief complaint on file.

Subjective**HISTORY OF PRESENT ILLNESS:**

Jennifer Lyn Brown is a 41-y.o. female.
 HPI

interval history:

thought to have RA though never really diagnosed with RA as symptoms improved and serology was negative, and HLA B 27 positive (2008)
 H/o anal fissure but no perianal abscess or fistula
 Gastric sleeve surgery (2013)
 evaluation done with colonoscopy in 6/2015 that showed ileal ulcerations and biopsies were positive for chronic active inflammation (details not mentioned in the report about features of chronicity). She was given prednisone course at that time and symptoms resolved.
 She underwent EGD/Colon and CTe in 6/2016 that showed active ileal disease.
 Intermittent constipation but symptoms of abdominal pain remain even after using laxatives and with complete evacuation of bowel.
 Started on Remicade 7/2016 but was switched to humaira later



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 11/22/2017

Notes (continued)**Progress Notes by Khan, Muhammad Z, MD at 11/22/2017 1:00 PM (continued)**

Now on humaira and methotrexate 25mg Q weekly

Done well since then. Minimal abdominal symptoms and no major joint symptoms so arthritic changes in knee joints

Bowel movements once or twice a day.

Formed.

She was having diarrhea two weeks ago, but it lasted only for few days and went away on its own

Otherwise no complaints today

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	



Notes Report

1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 11/22/2017

Notes (continued)

Progress Notes by Khan, Muhammad Z, MD at 11/22/2017 1:00 PM (continued)

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry Anxiety	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic Marfan syndrome	Father	
• Heart ?Marfan's Syndrome	Father	
• Heart Aortic Dissection, Marfan's Syndrome	Paternal Uncle	
• Psychiatry ADHD	Maternal Aunt	
• Genetic Marfan syndrome	Maternal Aunt	
• Psychiatry ADHD	Other	

Current Outpatient Prescriptions

Medication	Sig
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	TAKE ONE TABLET BY MOUTH ONCE DAILY
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle ONE TIME.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit	INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• methotrexate 2.5 MG Oral Tab	Take 25 mg by mouth EVERY 7 DAYS.
• Methotrexate 2.5 MG Oral Tab	Take 10 Tabs by mouth EVERY 7 DAYS.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS.
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
• venlafaxine (EFFEXOR XR) 75 MG Oral	Take 1 Cap by mouth DAILY.



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 11/22/2017**Notes (continued)****Progress Notes by Khan, Muhammad Z, MD at 11/22/2017 1:00 PM (continued)****CAPSULE SR 24 HR**

- Vitamin D, Ergocalciferol, (ERGOCALCIFEROL) 50000 units Oral Cap

Take 50,000 Units by mouth EVERY 7 DAYS.

Current Facility-Administered Medications**Medication**

- cyanocobalamin (VITAMIN B12) tablet 1,000 mcg

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

ReactionsSwelling
Rash
Rash**Social History****Social History Main Topics**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use: No
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/ protection: Pill, Condom
 - Comment: OCPs

Other Topics

- Not on file

Concern**Social History Narrative***August 2016: Works at Guthrie GI department. Lives with husband, has no children.***REVIEW OF SYSTEMS:****Review of Systems**

Constitutional: Negative.

HEENT: Negative.

Eyes: Negative.

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: Negative.

Genitourinary: Negative.

Musculoskeletal: Positive for joint pain.

Skin: Negative.

Neurological: Negative.

Endo/Heme/Allergies: Negative.



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 11/22/2017**Notes (continued)****Progress Notes by Khan, Muhammad Z, MD at 11/22/2017 1:00 PM (continued)**

Psychiatric/Behavioral: Negative.

Objective**PHYSICAL EXAM:**

VITALS: There were no vitals taken for this visit. There is no height or weight on file to calculate BMI.

Physical Exam

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: EOM are normal. Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

Musculoskeletal: Normal range of motion. She exhibits no edema.

Right knee: Tenderness found.

Left knee: Tenderness found.

Neurological: She is alert and oriented to person, place, and time. Gait normal. GCS score is 15.

Psychiatric: Mood, memory, affect and judgment normal.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM
1. Enteropathic arthritis	713.1	M07.60
2. Crohn's disease with complication, unspecified gastrointestinal tract location (HCC)	555.9	K50.919

Plan

Her GI symptoms have been stable, she has been off prednisone for quit some time now. She has been following GI

No joint symptoms

Overall no new concerns

She had recent blood work done

Follow up in 1 year

Author: Muhammad Z Khan, MD 11/22/2017 13:11

Electronically signed by Khan, Muhammad Z, MD at 12/4/2017 9:18 AM

Chart Cosign

Accepted By: Freeman, James, MD	Accepted On: 12/7/2017 9:09 PM
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Notes Report

1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 11/22/2017

Notes (continued)

Chart Cosign (continued)

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

11/22/2017 1:00 PM	Provider James Freeman	Department Sayre Rheumatology	Har	Center SAYRE
--------------------	---------------------------	----------------------------------	-----	-----------------

Office Visit
11/22/2017Jennifer Lyn Brown
MRN: 340616

Notes

Progress Notes by Freeman, James, MD at 11/22/2017 1:00 PM

Author: Freeman, James, MD	Service: —	Author Type: Physician
Filed: 12/7/2017 8:45 PM	Encounter Date: 11/22/2017	Status: Signed
Editor: Freeman, James, MD (Physician)		

I saw and evaluated the patient. Discussed with resident and agree with the resident's findings and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 12/7/2017 8:45 PM

Chart Cosign

Accepted By: Freeman, James, MD	Accepted On: 12/7/2017 9:09 PM
---------------------------------	--------------------------------

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	



Notes Report

141908280000384

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)

Patient Demographics (continued)

14894

Reg Status

PCP

Verified

Gillan, Michael F,
DO570-887-2239

Contact Information

	Provider	Department	Har	Center
8/22/2018 1:00 PM	James Freeman	Sayre Rheumatology		SAYRE

Office Visit

8/22/2018

Jennifer Lyn Brown

MRN: 340616

Notes

Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM

Author: Rahman, Hammad, MD

Service: —

Author Type: Resident

Filed: 8/26/2018 8:56 AM

Encounter Date: 8/22/2018

Status: Signed

Editor: Rahman, Hammad, MD (Resident)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 8/22/2018

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up
flare

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 41-y.o. female.

HPI

With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira later on humaira and methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Pt comes in for the one year follow up appointment. At this time, she was feeling fine until about 3 weeks ago when she started to notice some swelling of her both hands especially finger joints. Also complaining of some elbow stiffness. Her last arthritis flare was about 3 years ago and has been doing fairly well otherwise. She has been on the same dose of methotrexate and Humira for few years. Denies any fevers, chills, nodules, GI symptoms, back pain, toe swelling, knee pain, hip pain. Has been compliant with medications.

Past Medical History:

Diagnosis

- Anal fissure

Date

1/2013



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)

Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM (continued)

- Anxiety
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- CT 2005
- Crohn disease (HCC)
- Depression 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
• Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
• Marfan syndrome		



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)

Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM (continued)

• Heart	Father
<i>?Marfan's Syndrome</i>	
• Clotting Disorder	Father
• Heart Disease	Father
• Heart	Paternal Uncle
<i>Aortic Dissection, Marfan's Syndrome</i>	
• Heart Disease	Paternal Uncle
• Diabetes	Maternal Grandfather
• Thyroid Disease	Maternal Grandfather
• Macular Degeneration	Paternal Grandmother
• Psychiatry	Maternal Aunt
<i>ADHD</i>	
• Genetic	Maternal Aunt
<i>Marfan syndrome</i>	
• Psychiatry	Other
<i>ADHD</i>	
• Cancer	Paternal Grandfather
• Glaucoma	No family history
• Blindness	No family history
• Other Eye Problems	No family history
• Anesth Problems	No family history

Current Outpatient Prescriptions

Medication	Sig
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit	INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS
• LEVONEST Oral Tab	TAKE ONE TABLET BY MOUTH ONCE DAILY
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Methotrexate 2.5 MG Oral Tab	Take 10 Tabs by mouth EVERY 7 DAYS.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.



Notes Report

1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)**Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM (continued)**

- | | |
|---|---|
| • predniSONE (DELTASONE) 10 MG Oral Tab | Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop |
| • Probiotic Product (VSL#3) Oral Cap | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. |
| • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR | Inject 1 mL of Vit B12 IM every 30 days |
| • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS. |
| | Take 1 Cap by mouth DAILY. |

No current facility-administered medications for this visit.

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Rash
Rash

Social History**Social History Main Topics**

- | | |
|----------------------------|--------------|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | Never Used |
| • Alcohol use | No |
| • Drug use: | No |
| • Sexual activity: | Yes |
| Partners: | Male |
| Birth control/ protection: | Pill, Condom |
| Comment: OCPs | |

Other Topics

- Not on file

Concern

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:**Review of Systems**

Constitutional: Negative for chills, diaphoresis, fever, malaise/fatigue and weight loss.

HENT: Negative for congestion, ear discharge, ear pain, hearing loss, nosebleeds and tinnitus.

Eyes: Negative for blurred vision, double vision, photophobia and pain.

Respiratory: Negative for cough, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal: Negative for abdominal pain, constipation, diarrhea, heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency, hematuria and urgency.

Musculoskeletal: Positive for joint pain (swelling and pain of interphalangeal joints, more on the left hand).



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)**Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM (continued)**

Negative for back pain, falls, myalgias and neck pain.

Skin: Negative for rash.

Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, weakness and headaches.

Endo/Heme/Allergies: Does not bruise/bleed easily.

Psychiatric/Behavioral: Negative for depression and memory loss.

Objective**PHYSICAL EXAM:**VITALS: BP 110/76 | Ht 5' 11" (1.803 m) | Wt 290 lb (131.5 kg) | BMI 40.45 kg/m² Body mass index is 40.45 kg/m².**Physical Exam**

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and intact distal pulses.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

Musculoskeletal: She exhibits no edema or deformity.

Right elbow: Normal. She exhibits normal range of motion.

Left elbow: Normal. She exhibits normal range of motion.

Right wrist: Normal.

Left wrist: Normal.

Right knee: Normal. She exhibits normal range of motion and no swelling.

Left knee: Normal. She exhibits normal range of motion and no swelling.

Right ankle: Normal. She exhibits no swelling.

Left ankle: She exhibits normal range of motion and no swelling.

Right hand: She exhibits tenderness and swelling. She exhibits normal range of motion and no bony tenderness.

Left hand: She exhibits decreased range of motion, tenderness (**3 lateral fingers of left hand**), bony tenderness and swelling (**3 lateral fingers of left hand**). She exhibits no deformity and no laceration.**Lymphadenopathy:**

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes. No cranial nerve deficit. Gait normal. GCS score is 15.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: Mood and affect normal.



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)

Progress Notes by Rahman, Hammad, MD at 8/22/2018 1:00 PM (continued)

ASSESSMENT / IMPRESSION:

Plan

Rheumatoid arthritis/Enteropathic arthritis/Flare:

- Swelling of interphalangeal and metacarpo-phalangeal joint, more in left hand.
- CDAI score: 18.
- Will give patient prednisone 12 day course.
- Discussed with the patient option of switching oral methotrexate to injection as she has poor gut absorption. She call how she responds to prednisone.

Pt was seen and discussed with Dr. Freeman

Author: Hammad Rahman, MD 8/22/2018 20:15

Electronically signed by Rahman, Hammad, MD at 8/26/2018 8:56 AM

Chart Cosign

Accepted By	Accepted On
Freeman, James, MD	9/12/2018 1:22 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
8/22/2018 1:00 PM	James Freeman	Sayre Rheumatology		SAYRE

Office Visit
8/22/2018Jennifer Lyn Brown
MRN: 340616

Notes

Progress Notes by Freeman, James, MD at 8/22/2018 1:00 PM



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/22/2018

Notes (continued)

Progress Notes by Freeman, James, MD at 8/22/2018 1:00 PM (continued)

Author: Freeman, James, MD

Service: —

Author Type: Physician

Filed: 8/30/2018 9:10 AM

Encounter Date: 8/22/2018

Status: Signed

Editor: Freeman, James, MD (Physician)

I saw and evaluated the patient. Discussed with resident and agree with the resident's findings and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 8/30/2018 9:10 AM

Chart Cosign

Accepted By:

Freeman, James, MD

Accepted On:

9/12/2018 1:22 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

	Provider	Department	Har	Center
9/26/2018 2:20 PM	James Freeman	Sayre Rheumatology		SAYRE

Office Visit
9/26/2018

Jennifer Lyn Brown
MRN: 340616

Notes

Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM

Author: Rahman, Hammad, MD

Service: —

Author Type: Resident

Filed: 9/27/2018 4:07 PM

Encounter Date: 9/26/2018

Status: Signed

Editor: Rahman, Hammad, MD (Resident)

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/26/2018



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/26/2018

Notes (continued)**Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)****CHIEF COMPLAINT:**

Chief Complaint

Patient presents with

- Follow Up

Subjective**HISTORY OF PRESENT ILLNESS:**

Jennifer Lyn Brown is a 41-y.o. female.

HPI

With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira later on humaira and methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Pt was seen last month for the follow up of RA and at that time she was having some joint inflammations and was given prednisone taper for 12 days. As soon as she finished her prednisone, she developed diarrhea, she called GI and also she has worsening fatigue and stiffness in the joint, so she was started on prednisone 20 mg by GI. She is on that dose for last 20 days.

Today she feels little better, her arthritis is slightly better as well as the nausea. About 3-4 days, she was not able to move her wrists. She says that she feels tired and lethargic all the time and it is worse than before. Mainly the inflammation and stiffness started in her fingers and then wrist and then the other hands fingers and wrist as well as the toes. She feels like her fingers are burning.

Her ESR has always been in the normal range. She has allergic to remicade in the past, had possible drug induced lupus.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/26/2018

Notes (continued)

Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)

• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0) <i>Sees Dr. Freeman in Elmira.</i>	12/12/2008
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry <i>Anxiety</i>	Mother	
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic <i>Marfan syndrome</i>	Father	
• Heart <i>?Marfan's Syndrome</i>	Father	
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart <i>Aortic Dissection, Marfan's Syndrome</i>	Paternal Uncle	
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry <i>ADHD</i>	Maternal Aunt	
• Genetic <i>Marfan syndrome</i>	Maternal Aunt	
• Psychiatry <i>ADHD</i>	Other	
• Cancer.	Paternal Grandfather	
• Glaucoma	No family history	



Notes Report 1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 9/26/2018

Notes (continued)

Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)

- | | |
|----------------------|-------------------|
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Prescriptions

- | Medication | Sig |
|--|--|
| • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE) 600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution | Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. |
| • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. |
| • HUMIRA PEN 40 MG/0.8ML Subcutaneous Pen-injector Kit | INJECT 40MG BENEATH THE SKIN EVERY 7 DAYS |
| • Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc | Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly |
| • levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab | Take 1 Tab by mouth DAILY. |
| • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • [START ON 9/29/2018] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution | Inject 1 mL beneath the skin EVERY SATURDAY. |
| • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE | Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG Oral Tab EC | Take 1 Tab by mouth DAILY. |
| • predniSONE (DELTASONE) 10 MG Oral Tab | Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop (Patient taking differently: 20 mg. Take 4 tab x 3 days, then 3 tab x 3 days, then 2 tab x 3 days, then 1 tab x 3 days and stop) |
| • Probiotic Product (VSL#3) Oral Cap | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days |
| • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth EVERY TWENTY-FOUR HOURS. |
| • venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth DAILY. |

No current facility-administered medications for this visit.



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/26/2018

Notes (continued)**Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)****Allergies****Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Rash
Rash

Social History**Social History Main Topics**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use: No
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/ protection: Pill, Condom
 - Comment: OCPs

Other Topics

- Not on file

Concern

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:**Review of Systems**

Constitutional: Positive for malaise/fatigue. Negative for chills, diaphoresis, fever and weight loss.

HENT: Negative for congestion, ear discharge, ear pain, hearing loss, nosebleeds and tinnitus.

Eyes: Negative for blurred vision, double vision, photophobia and pain.

Respiratory: Negative for cough, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal: Negative for abdominal pain, constipation, diarrhea, heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency, hematuria and urgency.

Musculoskeletal: Positive for joint pain. Negative for back pain, falls, myalgias and neck pain.

Skin: Negative for rash.

Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, weakness and headaches.

Endo/Heme/Allergies: Does not bruise/bleed easily.

Psychiatric/Behavioral: Negative for depression and memory loss.

Objective**PHYSICAL EXAM:**

VITALS: BP 110/80 | Ht 5' 11" (1.803 m) | Wt 296 lb (134.3 kg) | BMI 41.28 kg/m² Body mass index is 41.28 kg/m².

Physical Exam



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/26/2018

Notes (continued)**Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)**

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat: Oropharynx is clear and moist.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and intact distal pulses.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

Musculoskeletal: She exhibits no edema or deformity.

Right shoulder: Normal. She exhibits normal range of motion and no tenderness.

Left shoulder: Normal. She exhibits normal range of motion and no tenderness.

Right elbow: She exhibits normal range of motion and no swelling.

Left elbow: She exhibits normal range of motion and no swelling.

Right wrist: She exhibits normal range of motion and no tenderness.

Left wrist: She exhibits normal range of motion and no tenderness.

Right hand: She exhibits swelling. She exhibits normal range of motion, no tenderness, no bony tenderness and no laceration.

Left hand: She exhibits swelling. She exhibits normal range of motion, no tenderness and no bony tenderness.

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes. No cranial nerve deficit. Gait normal. GCS score is 15.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: Mood and affect normal.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. Rheumatoid arthritis involving multiple sites with positive rheumatoid factor (HCC)	714.0	M05.79	ANTI NUCLEAR ANTIBODY
			ANTI HISTONE ANTIBODY
2. Crohn's disease without complication, unspecified gastrointestinal tract location (HCC)	555.9	K50.90	

Plan

Rheumatoid arthritis:

Generated on 8/19/19 10:49 AM



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 9/26/2018**Notes (continued)****Progress Notes by Rahman, Hammad, MD at 9/26/2018 2:20 PM (continued)**

- Due to recent flares and taking prednisone for longer duration is risky, will change oral methotrexate to SQ methotrexate 25 mg for better absorption as she has Crohn disease as well.
- CDAI score around 20.
- if this does not help, we might have to change Humira.
- Will check ANA and anti-histone antibodies to see if she has reaction to Humira. Advised to go down to prednisone 10 mg and see.

Crohn disease:

- as per GI.

Follow up in 6 weeks.

Pt was seen and discussed with Dr. Freeman.

Author: Hammad Rahman, MD 9/27/2018 16:05

Electronically signed by Rahman, Hammad, MD at 9/27/2018 4:07 PM

Chart Cosign

Accepted By:	Accepted On:
Freeman, James, MD	11/28/2018 2:51 PM

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (41 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

9/26/2018 2:20 PM	Provider	Department	Har	Center
	James Freeman	Sayre Rheumatology		SAYRE

Office Visit
9/26/2018Jennifer Lyn Brown
MRN: 340616**Notes****Progress Notes by Freeman, James, MD at 9/26/2018 2:20 PM**



Notes Report

141908280000384

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/26/2018

Notes (continued)**Progress Notes by Freeman, James, MD at 9/26/2018 2:20 PM (continued)**

Author: Freeman, James, MD	Service: —	Author Type: Physician
Filed: 10/3/2018 1:38 PM	Encounter Date: 9/26/2018	Status: Signed
Editor: Freeman, James, MD (Physician)		

I saw and evaluated the patient. Discussed with resident and agree with the resident's findings and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 10/3/2018 1:38 PM

Chart Cosign

Accepted By: Freeman, James, MD	Accepted On: 11/28/2018 2:51 PM
---------------------------------	---------------------------------

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

1/2/2019 3:00 PM	Provider James Freeman	Department Sayre Rheumatology	Har	Center SAYRE
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Office Visit

1/2/2019

Jennifer Lyn Brown

MRN: 340616

Notes**Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM**

Author: Regmi, Asish, MD	Service: —	Author Type: Resident
Filed: 1/13/2019 6:06 PM	Encounter Date: 1/2/2019	Status: Signed
Editor: Regmi, Asish, MD (Resident)		

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/2/2019



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/2/2019**Notes (continued)****Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)****CHIEF COMPLAINT:**

Chief Complaint

Patient presents with

- Follow Up

Subjective**HISTORY OF PRESENT ILLNESS:**

Jennifer Lyn Brown is a 42-y.o. female is here for regular follow up visit.

HPI

Jennifer Lyn Brown is a 42-y.o. Female With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humaira, now changed to Ustekinumab by GI, methotrexate 25mg Q weekly, FHx of RA, grandmother with Crohn's s/p bowel resection (required stoma).

Patient was seen here on sept for flare up.

Patient has also been following GI for crohn's disease.

Patient said that after she was started on Ustekinumab her swelling has gone better she still has pain.

She has pain in her wrist and knuckles. The pain is usually worst in the morning and she also has stiffness with it, and slowly gets better after day progress.

She says that she has been on stress lately because her father passed away and was taking her prednisone for few days and which caused her pain to get worsen.

In her recent lab anti histone and ANA were positive.

Past Medical History:

Diagnosis

Date

• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/2/2019

Notes (continued)

Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)

• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
ADHD		
• Genetic	Maternal Aunt	
Marfan syndrome		
• Psychiatry	Other	
ADHD		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/2/2019

Notes (continued)

Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)

Current Outpatient Medications

Medication	Sig
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• diclofenac (VOLTAREN) 1 % Transdermal Gel	2 g by Topical route FOUR TIMES DAILY.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 1 mL beneath the skin EVERY SATURDAY.
• Nitroglycerin 0.4 % Rectal Ointment	Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.
• prednisONE (DELTASONE) 10 MG Oral Tab	Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days (Patient taking differently: 20 mg. Begin 3 tabs each am. Reduce by 1/2 tab daily every 10 days)
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS.
• Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Inject 1 mL of Vit B12 IM every 30 days Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	TAKE ONE CAPSULE BY MOUTH EVERY 24 HOURS
• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/2/2019

Notes (continued)**Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)****Current Facility-Administered Medications****Medication**

- saline (OCEAN) nasal spray 0.65 %

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling

Rash

Rash

Social History**Socioeconomic History**

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity - worry: Not on file
- Food insecurity - inability: Not on file
- Transportation needs - medical: Not on file
- Transportation needs - non-medical: Not on file

Occupational History

- Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 oz
- Drug use: No
- Sexual activity: Yes
- Partners: Male
- Birth control/protection: Pill, Condom
- Comment: OCPs

Other Topics

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:**Review of Systems**

Constitutional: Negative for chills, fever and weight loss.



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/2/2019

Notes (continued)**Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)**

HENT: Negative for ear pain, hearing loss and tinnitus.

Eyes: Negative for blurred vision, double vision and photophobia.

Respiratory: Negative for cough, hemoptysis and sputum production.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and claudication.

Gastrointestinal: Negative for heartburn, nausea and vomiting.

Genitourinary: Negative for dysuria, frequency and urgency.

Musculoskeletal: Positive for joint pain.

Skin: Negative for itching and rash.

Neurological: Negative for dizziness, tingling and headaches.

Endo/Heme/Allergies: Negative for environmental allergies. Does not bruise/bleed easily.

Objective**PHYSICAL EXAM:**VITALS: BP 130/70 | Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m² Body mass index is 39.89 kg/m².**Physical Exam**

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate and regular rhythm. Exam reveals no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema.

Tenderness in wrist joint.**Tender point in shoulder and hip as well**

Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit. Coordination normal.

Skin: Skin is warm and dry.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM
1. Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC)	714.0	M05.731
		M05.732

Plan**Rheumatoid arthritis:**

Recently changed from humeria to UStekinumab by GI.

Still having some pain.

Still on tapering steroids.

Patient also no methotrexate.



Notes Report

141908280000384

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/2/2019

Notes (continued)**Progress Notes by Regmi, Asish, MD at 1/2/2019 3:00 PM (continued)**

Patient to continue with same medication.

Fibromyalgia:

She has tender points in her body.

Most likely has some component of fibromyalgia.

Will start her on flexeril for now. Her PCP to decide on further medication.

Follow in 4 months.

D/W Dr freeman and agreed upon.

Author: Asish Regmi, MD 1/2/2019 15:49

Electronically signed by Regmi, Asish, MD at 1/13/2019 6:06 PM

Chart Cosign

Required By: 141908280000384
James Freeman, MD[JFREEMAN]

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

1/2/2019 3:00 PM	Provider	Department	Har	Center
	James Freeman	Sayre Rheumatology		SAYRE

Office Visit
1/2/2019

Jennifer Lyn Brown
MRN: 340616

Notes**Progress Notes by Freeman, James, MD at 1/2/2019 3:00 PM**



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/2/2019

Notes (continued)

Progress Notes by Freeman, James, MD at 1/2/2019 3:00 PM (continued)

Author: Freeman, James, MD	Service: —	Author Type: Physician
Filed: 1/16/2019 1:18 PM	Encounter Date: 1/2/2019	Status: Signed
Editor: Freeman, James, MD (Physician)		

I saw and evaluated the patient. Discussed with resident and agree with the resident's findings and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 1/16/2019 1:18 PM

Chart Cosign

Required By: James Freeman, MD[JFREEMAN]

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (42 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Contact Information

7/10/2019 3:40 PM	Provider James Freeman	Department Sayre Rheumatology	Har	Center SAYRE
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Office Visit
7/10/2019

Jennifer Lyn Brown
MRN: 340616

Notes

Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM

Author: Freeman, James, MD	Service: —	Author Type: Physician
Filed: 7/17/2019 5:06 PM	Encounter Date: 7/10/2019	Status: Signed
Editor: Freeman, James, MD (Physician)		

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 7/10/2019



Notes Report

1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/10/2019

Notes (continued)

Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI Jennifer Lyn Brown is a 42-y.o. female is here for her follow up visit.

HPI

Jennifer Lyn Brown is a 42-y.o. Female With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humira after she developed skin rash and allergy to remicade. She developed drug induced lupus on Humira, and then changed to Ustekinumab by GI, methotrexate 25mg SC Q weekly. She had been doing well until she underwent shoulder surgery a few months ago. The recovery has been slow. In addition, she has been under a lot of stress due to work and family issues. She finally stopped working. In any case, she has had more aches and pains in her hips and knees without swelling. Morning stiffness under 20 minutes. She isn't sure if the joint pains are related to more active arthritis vs stress vs both. She is having no trouble tolerating her medications in the way of infections, stomach upset, or lab abnormalities. Recent ESR was normal. Her Crohn's symptoms have been well controlled.

Past Medical History:

Diagnosis

Date

• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS CT 2005	5/23/2005
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
• irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 7/10/2019

Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)

- Page 29
-
- 806



Notes Report

1 4 1 9 0 8 2 8 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/10/2019

Notes (continued)

Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- HYDROcodone-acetaminophen (NORCO) 5-325 MG Oral Tab Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (Pain, continued treatment). Max Daily Amount: 6 Tabs.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS.
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 1 mL of Vit B12 IM every 30 days
Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.



Notes Report

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/10/2019

Notes (continued)**Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)****Current Facility-Administered Medications****Medication**

- saline (OCEAN) nasal spray 0.65 %

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Oxycodone
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Hives
Rash
Rash

Social History**Socioeconomic History**

- Marital status: Separated
 - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs:
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity:
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections:
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file



Notes Report 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/10/2019

Notes (continued)**Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)**

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

- Intimate partner violence:
 - Fear of current or ex partner: Not on file
 - Emotionally abused: Not on file
 - Physically abused: Not on file
 - Forced sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative.

HENT: Negative.

Eyes: Negative.

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: Positive for abdominal pain.

She has intermittent RLQ discomfort attributed to ovarian cyst

Musculoskeletal: Positive for joint pain.

Skin: Negative.

Neurological: Negative.

Endo/Heme/Allergies: Negative.

Objective**PHYSICAL EXAM:**

VITALS: BP 110/70 | Ht 5' 11" (1.803 m) | Wt 279 lb (126.6 kg) | BMI 38.91 kg/m² Body mass index is 38.91 kg/m².

Physical Exam

Constitutional: She appears well-developed.

Eyes: Conjunctivae are normal.

Neck: Normal range of motion. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

Pulmonary/Chest: Breath sounds normal.

Abdominal: Soft.

Musculoskeletal: Normal range of motion. She exhibits no edema, tenderness or deformity.

ASSESSMENT / IMPRESSION:



GUTHRIE[®]

Notes Report

141908280000384

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/10/2019

Notes (continued)

Progress Notes by Freeman, James, MD at 7/10/2019 3:40 PM (continued)

Enteropathic arthritis

Plan

Continue current therapy

RV 3 months

Author: James Freeman, MD 7/17/2019 17:03

Electronically signed by Freeman, James, MD at 7/17/2019 5:06 PM


 141908280000384
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Stethers, Lonnie, NP570-888-5858			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

SEDIMENTATION RATE (Order 28319990)

Status: Final result

Result

(Collected: 9/3/2008 11:12 AM)

SEDIMENTATION RATE [28319990]

Resulted: 09/03/08 1252, Result status: Final
result

Filed on: 09/03/08 1253

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
ESR	10	0 - 20 MM/HR	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)

1 4 1 9 0 8 2 8 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

Patient Demographics (continued)

Address	Phone	Email	Employer
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES
Reg Status	PCP		
Verified	Stethers, Lonnie, NP570-888-5858		

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

HEPATITIS C ANTIBODY (Order 28319991)

Status: Final result
(Collected: 9/3/2008 11:12 AM)

Result

HEPATITIS C ANTIBODY [28319991]

Resulted: 09/03/08 1312, Result status: Final
result

Filed on: 09/03/08 1313

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
Hepatitis C Ab	NON REAC	NON REAC	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer LynMRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 9/3/2008

Notes (continued)

Patient Demographics (continued)

14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES
Reg Status Verified	PCP Stethers, Lonnie, NP570-888-5858		

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

RHEUMATOID FACTOR (Order 28319992)

Status: Final result
(Collected: 9/3/2008 11:12 AM)

Result

RHEUMATOID FACTOR [28319992]

Resulted: 09/03/08 1316, Result status: Final
result

Filed on: 09/03/08 1316

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
Rheumatoid Factor	<8.7	<15 IU/ml	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT	607-215-0584 (H)	jenlyn9598@yahoo.c	GUTHRIE MEDICAL	



1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

Patient Demographics (continued)

429	607-483-1886 (M)	om	GROUP
WELLSBURG NY			EMPLOYEES
14894			
Reg Status	PCP		
Verified	Stethers, Lonnie,		
	NP570-888-5858		

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

CYCLIC CITRULLINE PEPTIDE IGG (Order 28319993)

Status: Final result

Result

(Collected: 9/3/2008 11:12 AM)

CYCLIC CITRULLINE PEPTIDE IGG [28319993]

Resulted: 09/06/08 0822, Result status: Final
result

Filed on: 09/06/08 0824

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
CYCLIC CITRULLINE PE	<20	<20 UNITS	—	GMG
Comment:				
CLASSIFICATION	UNITS	INTERPRETATION	-----	
-----	NEGATIVE	<20	A NEGATIVE RESULT INDICATES	
NO		CCP IGG ANTIBODY PRESENT OR	-----	
LEVELS BELOW THE ASSAY CUTOFF.			-----	
-----	WEAK POSITIVE	20-39	A POSITIVE SEMI-	
QUANTITATIVE MODERATE POSITIVE	40-59	RESULT INDICATES THE PRESENCE OF	-----	
-----	CCP IGG ANTIBODIES OF INCREASING STRONG POSITIVE	> OR = 60	LEVELS. -----	

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

1 4 1 9 0 8 2 8 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Stethers, Lonnie, NP570-888-5858			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

C-REACTIVE PROTEIN (Order 28319994)

Status: Final result

Result

(Collected: 9/3/2008 11:12 AM)

C-REACTIVE PROTEIN [28319994] (Abnormal)

Resulted: 09/03/08 1316, Result status: Final
result

Filed on: 09/03/08 1316

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
C-Reactive Protein	0.68	0.00 - 0.30 mg/dl	H	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Stethers, Lonnie, NP570-888-5858			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

HLA B27 (Order 28319995)

Status: Final result

Result

(Collected: 9/3/2008 11:12 AM)

HLA B27 [28319995]

Resulted: 09/06/08 1024, Result status: Final
result

Filed on: 09/06/08 1026

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
Hla-B27	PRESENT	—	—	GMG
Comment: The HLA-B27 antigen is present in 9 percent of caucasian and 4 percent of black populations. The antigen is seen with a frequency of 90 percent in patients with ankylosing spondylitis and a frequency of 80 percent in patients with Reiter's disease.				

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC	Surya Narayanan	GUTHRIE SQUARE	09/06/06 0938 - 12/04/13

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

LABORATORY MD SAYRE PA 18840 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (31 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Stethers, Lonnie, NP570-888-5858			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

**PROTEIN ELECTROPHORESIS, SERUM (Order
28319996)
Result**
Status: Final result
(Collected: 9/3/2008 11:12 AM)

PROTEIN ELECTROPHORESIS, SERUM [28319996]

Resulted: 09/09/08 0856, Result status: Final
result

Filed on: 09/09/08 0857

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	09/03/08 1112

Components

Component	Value	Reference Range	Flag	Lab
SPEP	—	—	—	GMG
Total Protein	7.6	6.4 - 8.2 g/dl	—	GMG
Albumin	4.0	3.4 - 5.0 g/dl	—	GMG
Albumin - Speg	3.8	3.1 - 4.4 g/dl	—	GMG
Alpha 1 Globulin - Speg	0.3	0.1 - 0.4 g/dl	—	GMG
Alpha 2 Globulin - Speg	1.0	0.6 - 1.2 g/dl	—	GMG
Beta Globulin - Speg	1.1	0.7 - 1.3 g/dl	—	GMG
Gamma Globulin - Speg	1.4	0.6 - 1.7 g/dl	—	GMG

1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/3/2008

Notes (continued)

Speg Interpretation -- -- -- GMG

Result: NORMAL SERUM PROTEIN ELECTROPHORESIS PATTERN. S. Narayanan, MD.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

CBC WITH DIFFERENTIAL (Order 35220683)

Status: Final result
(Collected: 7/21/2009 8:26 AM)

Result

CBC WITH DIFFERENTIAL [35220683] (Abnormal)

Resulted: 07/21/09 0837, Result status: Final result

Filed on: 07/21/09 0838

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	07/21/09 0826

Components

Component	Value	Reference Range	Flag	Lab
CBC	—	—	—	GMG
WBC COUNT	9.7	3.6 - 11.0 K/uL	—	GMG


 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

RBC Count	4.72	3.80 - 5.20	—	GMG
		M/uL		
Hemoglobin	13.9	13.0 - 18.0	—	GMG
		G/DL		
Hematocrit	39.7	40.0 - 52.0 %	L	GMG
MCV	84.1	80.0 - 100.0 FL	—	GMG
MCH	29.5	26.0 - 34.0 PG	—	GMG
MCHC	35.1	32.0 - 36.0 %	—	GMG
Platelet Count	316	150 - 400 K/uL	—	GMG
MPV	7.9	7.1 - 11.2 FL	—	GMG
RDW	10.9	11.0 - 15.0 %	L	GMG
Neutrophil %	66.8	38.0 - 70.0 %	—	GMG
Lymphocyte %	24.4	21.0 - 49.0 %	—	GMG
Monocyte %	5.7	0.0 - 11.0 %	—	GMG
Eosinophil %	2.4	0.0 - 7.0 %	—	GMG
Basophil %	0.8	0.0 - 2.0 %	—	GMG
Neutrophil #	6.5	1.8 - 7.7 K/uL	—	GMG
Lymphocyte #	2.3	1.0 - 5.0 K/uL	—	GMG
Monocyte #	0.5	0.0 - 0.8 K/uL	—	GMG
Eosinophil #	0.2	0.0 - 0.5 K/uL	—	GMG
Basophil #	0.1	0.0 - 0.2 K/uL	—	GMG

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:



1 4 1 9 0 8 2 8 0 0 0 3 8 4

Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

Admission Information (continued)

Transfer Source:
Admit Provider:Service Area:
Attending
Provider:Unit:
Referring
Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

**COMPREHENSIVE METABOLIC PANEL (Order
35220684)
Result**
Status: Final result
(Collected: 7/21/2009 8:26 AM)

COMPREHENSIVE METABOLIC PANEL [35220684] (Abnormal)

Resulted: 07/21/09 0902, Result status: Final
result

Filed on: 07/21/09 0903

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	07/21/09 0826

Components

Component	Value	Reference Range	Flag	Lab
CMP	—	—	—	GMG
Sodium	139	136 - 145 mmol/l	—	GMG
Potassium	3.9	3.5 - 5.1 mmol/l	—	GMG
Chloride	103	98 - 107 mmol/l	—	GMG
CO2	30.4	21.0 - 32.0 mmol/l	—	GMG
Calcium	8.9	8.5 - 10.1 mg/dl	—	GMG
Albumin	3.6	3.4 - 5.0 g/dl	—	GMG
BUN	18	7 - 18 mg/dl	—	GMG
Creatinine	0.9	0.6 - 1.3 mg/dl	—	GMG
Glucose (Lab)	94	70 - 110 mg/dl	—	GMG
Total Protein	7.1	6.4 - 8.2 g/dl	—	GMG
Total Bilirubin	0.3	<1.0 mg/dl	—	GMG
AST	19	15 - 37 U/L	—	GMG
Alkaline Phosphatase	44	50 - 136 U/L	L	GMG
ALT	34	30 - 65 U/L	—	GMG
eGFR	77	ml/min	—	GMG

Comment:

Above 60 mL/min/1.73m² = Normal renal function 30-59 mL/min/1.73m² = Stage 3 Chronic Kidney Disease 15-29 mL/min/1.73m² = Stage 4 Chronic Kidney Disease Less than 15 mL/min/1.73m² = Stage 5 Chronic Kidney Disease Value calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation. It is an accurate estimate of GFR when serum creatinine is in steady state (not during acute illness), and patient is without exceptional dietary intake (e.g., vegetarian diet or creatine intake) or muscle mass (e.g., amputation, malnutrition, muscle wasting). MDRD equation: eGFR(ml/min/1.73m²) = 186 x (serum creatinine)^{-1.54} x (age)^{-0.203} x (0.742 if female) x (1.210 if African American) References: Levey


 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

AS, Green T, Kusek JW, Beck GJ: A simplified equation to predict glomerular filtration rate from serum creatinine. J Am Soc Nephrol 11:A0828, 2000 (abstract); KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. Available at http://www.kidney.org/professionals/kdoqi/guideline_ckd/toc.htm

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

SEDIMENTATION RATE (Order 35220685)

Result

 Status: Final result
 (Collected: 7/21/2009 8:26 AM)

SEDIMENTATION RATE [35220685]

Resulted: 07/21/09 1038, Result status: Final result

Filed on: 07/21/09 1038

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	07/21/09 0826



1 4 1 9 0 8 2 8 0 0 0 0 3 8 4

Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

Components

Component	Value	Reference Range	Flag	Lab
ESR	7	0 - 20 MM/HR	—	GMG

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

C-REACTIVE PROTEIN (Order 35220686)

Result

Status: Final result
(Collected: 7/21/2009 8:26 AM)

C-REACTIVE PROTEIN [35220686] (Abnormal)

Resulted: 07/21/09 1052, Result status: Final result

Filed on: 07/21/09 1053

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	07/21/09 0826


 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

Components

Component	Value	Reference Range	Flag	Lab
C-Reactive Protein	0.82	0.00 - 0.30 mg/dl	H	GMG

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
		Admit Category:
Admission Type:	Point of Origin:	Secondary
Means of Arrival:	Primary Service:	Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

THYROID STIMULATING HORMONE (Order 35220687)

Status: Final result

Result

(Collected: 7/21/2009 8:26 AM)

THYROID STIMULATING HORMONE [35220687]

Resulted: 07/21/09 0917, Result status: Final
result

Filed on: 07/21/09 0917

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
—	—	07/21/09 0826


 141908280000384
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

Components

Component	Value	Reference Range	Flag	Lab
TSH	2.04	0.32 - 5.00 ulu/ml	—	GMG

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (32 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Distefano, Kenneth, MD			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Laboratory

FREE T4 (Order 35220688)

Result

 Status: Final result
 (Collected: 7/21/2009 8:26 AM)

FREE T4 [35220688]

 Resulted: 07/21/09 0917, Result status: Final
 result

Filed on: 07/21/09 0917

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
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1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/21/2009

Notes (continued)

07/21/09 0826

Components

Component	Value	Reference Range	Flag	Lab
Free T4	1.05	0.71 - 1.85 ng/dl	—	GMG

Reviewed by

Freeman, James, MD on 12/23/09 1459

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Surya Narayanan MD	GUTHRIE SQUARE SAYRE PA 18840	09/06/06 0938 - 12/04/13 1529

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (37 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Internal Medicine

SEDIMENTATION RATE (Order 90306377)

Status: Final result

Result

(Collected: 7/16/2014 1:39 PM)

SEDIMENTATION RATE [90306377] (Normal)

Resulted: 07/16/14 1421, Result status: Final result

Ordering provider: Freeman, James, MD 07/16/14 1336 Filed on: 07/16/14 1343

Resulting lab: GUTHRIE CLINIC LABORATORY



1 4 1 9 0 8 2 8 0 0 0 3 8 4

Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/16/2014

Notes (continued)

Specimen Information

Type	Source	Collected On
Blood	—	07/16/14 1339

Components

Component	Value	Reference Range	Flag	Lab
ESR	14	0 - 20 mm	—	GMG

Reviewed by

Sproule, Megan, LPN on 11/14/14 1451

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Hartman, Ricky E, DO	1 GUTHRIE SQUARE SAYRE PA 18840	04/21/14 1021 - 05/11/15 1552

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (37 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Internal Medicine

SJOGRENS SYNDROME ANTIBODIES (Order 90306378)
Result

Status: Final result
(Collected: 7/16/2014 1:39 PM)

SJOGRENS SYNDROME ANTIBODIES [90306378]

Resulted: 07/21/14 1636, Result status: Final

141908280000384
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/16/2014

Notes (continued)

result

Ordering provider: Freeman, James, MD 07/16/14 1336 Filed on: 07/16/14 1343

Resulting lab: QUEST DIAGNOSTICS

Narrative:

Performing Organization Information:

Site ID: P

Name: QUEST DIAGNOSTICS

Address: 875 GREENTREE ROAD, 4 PARKWAY CENTER PITTSBURGH, PA 15220

Director:

Specimen Information

Type	Source	Collected On
Blood	—	07/16/14 1339

Components

Component	Value	Reference Range	Flag	Lab
SJOGREN'S ANTI-SS-A	<1.0 NEG	<1.0 NEG AI	—	36
SJOGREN'S ANTI-SS-B	<1.0 NEG	<1.0 NEG AI	—	36

Reviewed by

Sproule, Megan, LPN on 11/14/14 1451

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST DIAGNOSTICS	Unknown	875 GREENTREE RD 4 PARKWAY CENTER PITTSBURGH PA 15220	09/26/11 1434 - Present

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (37 yrs)
Address:	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.com	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:


 1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 7/16/2014

Notes (continued)

Admission Information (continued)

Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending	Referring
	Provider:	Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Internal Medicine

**GLUCOSE-6-PTASE DEHYDROGENASE (Order
90306379)**

 Status: Final result
 (Collected: 7/16/2014 1:39 PM)

Result

 Resulted: 07/19/14 1329, Result status: Final
 result

GLUCOSE-6-PTASE DEHYDROGENASE [90306379]

Ordering provider: Freeman, James, MD 07/16/14 1336 Filed on: 07/16/14 1342

Resulting lab: QUEST DIAGNOSTICS

Narrative:

Performing Organization Information:

Site ID: G

Name: QUEST DIAGNOSTICS NICHOLS INSTITUTE

Address: 14225 NEWBROOK DRIVE CHANTILLY, VA 20151

Director:

Specimen Information

Type	Source	Collected On
Blood	—	07/16/14 1339

Components

Component	Value	Reference Range	Flag	Lab
Glucose-6-Phase Dehydrogenase	8.1	4.6 - 13.5 U/g Hb	—	36

Reviewed by

Sproule, Megan, LPN on 11/14/14 1451

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST DIAGNOSTICS	Unknown	875 GREENTREE RD 4 PARKWAY CENTER PITTSBURGH PA 15220	09/26/11 1434 - Present

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (37 yrs)
Address	Phone	Email	Employer	


 1 4 1 9 0 8 2 8 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/20/2014

Notes (continued)

Patient Demographics (continued)

14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES
Reg Status Verified	PCP Gillan, Michael F, DO570-887-2239		

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
Admission Type:	Point of Origin:	Admit Category:
Means of Arrival:	Primary Service:	Secondary Service:
Transfer Source:	Service Area:	Unit:
Admit Provider:	Attending Provider:	Referring Provider:

Discharge Information

Discharge Date/Time None	Discharge Disposition None	Discharge Destination None	Discharge Provider None	Unit Sayre Orthopedics
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CBC WITH DIFFERENTIAL (Order 91252107)

Result

 Status: Final result
 (Collected: 8/20/2014 12:54 PM)

CBC WITH DIFFERENTIAL [91252107] (Abnormal)

 Resulted: 08/20/14 1308, Result status: Final
 result

Ordering provider: Sproule, Megan, LPN 08/20/14 1251 Filed on: 08/20/14 1259

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type Blood	Source —	Collected On 08/20/14 1254
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Components

Component	Value	Reference Range	Flag	Lab
WBC Count	19.6	3.6 - 11.0 K/uL	H	GMG
RBC Count	4.87	3.80 - 5.20 M/uL	—	GMG
Hemoglobin	14.6	12.0 - 16.0 g/dL	—	GMG
Hematocrit	43.5	35.0 - 47.0 %	—	GMG
MCV	89.2	80.0 - 100.0 fL	—	GMG
MCH	30.0	26.0 - 34.0 pg	—	GMG
MCHC	33.6	32.0 - 36.0 g/dL	—	GMG
Platelet Count	292	150 - 400 K/uL	—	GMG
MPV	7.9	7.1 - 11.2 fL	—	GMG
RDW	13.1	11.0 - 15.0 %	—	GMG
Neutrophil %	72.5	38.0 - 70.0 %	H	GMG
Lymphocyte %	19.6	21.0 - 49.0 %	L	GMG
Monocyte %	6.7	0.0 - 11.0 %	—	GMG



1 4 1 9 0 8 2 8 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/20/2014

Notes (continued)

Eosinophil %	0.6	0.0 - 7.0 %	—	GMG
Basophil %	0.6	0.0 - 2.0 %	—	GMG
Neutrophil #	14.2	1.8 - 7.7 K/uL	H	GMG
Lymphocyte #	3.8	1.0 - 5.0 K/uL	—	GMG
Monocyte #	1.3	0.0 - 0.8 K/uL	H	GMG
Eosinophil #	0.1	0.0 - 0.5 K/uL	—	GMG
Basophil #	0.1	0.0 - 0.2 K/uL	—	GMG

Reviewed by

Sproule, Megan, LPN on 11/14/14 1452

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE CLINIC LABORATORY	Hartman, Ricky E, DO	1 GUTHRIE SQUARE SAYRE PA 18840	04/21/14 1021 - 05/11/15 1552

Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
Brown, Jennifer Lyn	340616	xxx-xx-2507	Female	10/26/76 (37 yrs)
Address	Phone	Email	Employer	
14 MAIN ST LOT 429 WELLSBURG NY 14894	607-215-0584 (H) 607-483-1886 (M)	jenlyn9598@yahoo.c om	GUTHRIE MEDICAL GROUP EMPLOYEES	
Reg Status	PCP			
Verified	Gillan, Michael F, DO570-887-2239			

Admission Information

Arrival Date/Time:	Admit Date/Time:	IP Adm. Date/Time:
		Admit Category:
Admission Type:	Point of Origin:	Secondary
Means of Arrival:	Primary Service:	Service:
		Unit:
Transfer Source:	Service Area:	Referring
Admit Provider:	Attending Provider:	Provider:

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	Sayre Orthopedics

COMPREHENSIVE METABOLIC PANEL (Order 91252108)

Result

Status: Final result
(Collected: 8/20/2014 12:54 PM)

COMPREHENSIVE METABOLIC PANEL [91252108]

Resulted: 08/20/14 1334, Result status: Final
result


 1 4 1 9 0 8 2 8 0 0 0 3 8 4
 Pathology Result Report Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 8/20/2014

Notes (continued)

Ordering provider: Sproule, Megan, LPN 08/20/14 1251 Filed on: 08/20/14 1259

Resulting lab: GUTHRIE CLINIC LABORATORY

Specimen Information

Type	Source	Collected On
Blood	—	08/20/14 1254

Components

Component	Value	Reference Range	Flag	Lab
Sodium	137	134 - 145 mmol/L	—	GMG
Potassium	3.9	3.5 - 5.1 mmol/L	—	GMG
Chloride	99	98 - 107 mmol/L	—	GMG
CO2	26	22 - 30 mmol/L	—	GMG
Calcium	9.6	8.3 - 10.1 mg/dL	—	GMG
Albumin	4.3	3.5 - 5.0 g/dL	—	GMG
BUN	13	7 - 17 mg/dL	—	GMG
Creatinine	0.7	0.7 - 1.2 mg/dL	—	GMG
Glucose	90	70 - 110 mg/dL	—	GMG
Total Protein	8.0	6.3 - 8.2 g/dL	—	GMG
Total Bilirubin	0.5	0.0 - 1.1 mg/dL	—	GMG
AST	35	15 - 46 U/L	—	GMG
Alkaline Phosphatase	51	38 - 126 U/L	—	GMG
ALT	45	9 - 52 U/L	—	GMG
eGFR	>60	ml/min/1.73mL	—	GMG

Comment:

Estimated GFR Interpretation:

Above 60ml/min/1.73m2 = Normal Renal Function

30-59 ml/min/1.73m2 = Stage 3 Chronic Kidney Disease

15-29 ml/min/1.73m2 = Stage 4 Chronic Kidney Disease

Less than 15 ml/min/1.73m2 = Stage 5 Chronic Kidney Disease

The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation:

$$eGFR(\text{ml/min/1.73m}^2) = 175 \times (\text{serum creatinine})^{-1.54} \times (\text{age})^{-0.203} \times (0.742 \text{ if female}) \times (1.210 \text{ if African American})$$

The estimated GFR is calculated without consideration for patient weight.

References and further information can be found at:

www.kidney.org/professionals/kls/pdf/12-10-4004_ABE_FAQs_AboutGFRrev1b

Reviewed by

Sproule, Megan, LPN on 11/14/14 1452

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
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**GUTHRIE**1 4 1 9 0 8 2 8 0 0 0 0 3 8 4
Pathology Result Report Brown, Jennifer LynMRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 8/20/2014**Notes (continued)****6 - GMG**GUTHRIE CLINIC
LABORATORYHartman, Ricky
E, DO1 GUTHRIE
SQUARE
SAYRE PA 1884004/21/14 1021 - 05/11/15
1552

END OF REPORT

Pueblo, CO 81002



866-390-7404
719-542-2564 (FAX)
www.verisma.com

NYS Office of Temporary and Disability Assistance, Division of Disability
Determinations
K. RICHARDSON
PO Box 8783
London, KY 40742-9927

Date: 8/7/2019

Invoice #: 6020-72842

WE ARE UNABLE TO FULFILL YOUR REQUEST FOR MEDICAL RECORDS

Patient Name: Brown, Jennifer
Case #: F003DAD0A
Medical Provider: Guthrie Clinic-Sayre Clinic
Guthrie Square, Sayre, PA 18840

Dear Medical Records Requestor:

Verisma Systems, Inc. has contracted with the medical provider noted above to provide HIPAA compliance review and distribute medical records on its behalf. An issue concerning the attached request has been detected. Your request will not be processed due to the following issue(s):

There are no applicable records for the dates of service requested.

In order to process your request for medical records, a new request/authorization addressing the issue(s) must be provided to the medical facility from where you are requesting records.

Please contact our Customer Service Team with questions:

Telephone: 866-390-7404

STATEMENT OF CONFIDENTIALITY

THIS INFORMATION IS INTENDED FOR THE EXCLUSIVE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL OR PRIVILEGED INFORMATION. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY RETENTION, COPYING, DISSEMINATION, OR USE OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF THIS WAS SENT IN ERROR, PLEASE NOTIFY Verisma Systems, Inc., AT 866-390-7404 AND DESTROY THIS COMMUNICATION AND ANY ATTACHMENTS.

Please send all available medical records including imaging, diagnostics, and testing, from 06/19/2017 to present. Formerly known as Jennifer Lyn Evans. . Part you.

EXHIBIT NO. B6F
PAGE: 2 OF 6

Patient ID Number: Date of Last Exam:

Frequency of Treatment: Date First Seen:

Height: Weight:

Blood Pressure, Most Recent, Significant Changes Noted:

Treating Diagnoses:

Please indicate current symptoms:

Treatment and Response:

Please include medications prescribed with dosage and frequency, side effects, and any surgical procedures performed:

Please indicate the expected duration and prognosis of the claimant's condition:

If your patient has displayed any behavior suggestive of a significant psychiatric disorder, please describe (with dates):

If weight loss, please provide representative weights over at least a 3 month period and comment on expected persistence:

Past and present symptoms with dates and severity (i.e., pain, hemorrhage, jaundice, anorexia, ascites, nausea, vomiting, diarrhea, weakness, arthritis, iritis, fever etc):

Laboratory Findings:

Please include chest x-rays, angiography, catheterization, echocardiography, contrast, or radio-isotopic ventriculography (with dates):

In cases of peripheral arterial disease, please give results of arteriography, plethysmography, or Doppler. (If Doppler exercise studies were performed, indicate speed and grade of treadmill, duration, symptoms, systolic BPs before and after exercise and time required for return to pre-exercise systolic BP.)

Describe any limitations of physical activity as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity; include specific symptoms and resulting limitations.

Based on the medical findings provided in my report, my medical opinion regarding this individual's ability to do work-related physical activities is as follows:

- Lift and Carry
 - ☐ No Limitation ☐ Limited (Please specify both below)
 - ☐ Occasionally (up to 1/3 of a work day): lbs.
 - ☐ Frequently (up to 2/3 of a work day): lbs.
 - Maximum number of pounds that can be lifted and carried is: lbs.
- Stand and/or Walk
 - ☐ No Limitation ☐ Limited (please check extent below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Up to 2 hours per day ☐ Less than 2 hours per day
- Sit
 - ☐ No Limitation ☐ Limited (please check one below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Less than 6 hours per day
- Push and/or Pull (including hand & foot controls)
 - ☐ No Limitation ☐ Limited (please specify below)
 - ☐ Upper extremities (please describe)
- Other (e.g. postural, manipulative, visual, communicative, environmental)
 - ☐ No Limitation ☐ Limited (please describe below)

☐ I cannot provide a medical opinion regarding this individual's ability to do work-related activities.

Are there any other conditions significant to recovery? ☐ No ☐ Yes

- If yes, please record your comments below. (If necessary, the reverse of this page may be used.)

Please indicate the best days and times for us to call if we need to ask for additional or clarifying information. Day: Time:

Facility _____ Phone _____

Signature _____ Title _____

Name Printed _____ Date _____

PREETIKA SINH, MD
1 GUTHRIE SQUARE
SAYRE, PA 18840

Form Approved
OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME (First, Middle, Last, Suffix)

JENNIFER LYN BROWN

SSN

132-58-2507

Birthday
(mm/dd/yy)

10/26/76

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) **including, and not limited to:**
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure

SIGN  Electronically Signed By:
JENNIFER LYN BROWN

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law) 

Date Signed

06/19/19

Street Address

14 MAIN ST LOT 429

Phone Number (with area code)

607-215-0584

City

WELLSBURG

State

NY

ZIP

14894

WITNESS I know the person signing this form or am satisfied of this person's identity:**SIGN** 

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN 

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Form SSA-827 (11-2012) of (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted

Page 1 of 2

"Authorization to Disclose Information to the Social Security Administration (SSA)" PAGE: 6 OF 6

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SSA to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

Other than the above limited circumstances, SSA will not redisclose without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, state, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the clearance requirements of 44 U.S.C. section 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR DELIVER THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call 800 772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to:

SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.

Industrial Medicine Associates, P.C.
Binghamton, New York

Claimant's Name: BROWN, JENNIFER L V/139/9749 F190VMN

Date: 08/21/2019

Provider's Name: AMANDA SLOWIK, PSY.D.

ID#4316153

DOB: 10/26/1976

PSYCHIATRIC EVALUATION

BACKGROUND INFORMATION: The claimant is a separated 42-year-old female who drove herself to the appointment today. The claimant resides with her boyfriend. She obtained her high school diploma in 1995 and was in a combination of regular and special education classes in school. She particularly received special education programming because of difficulties with math. She then obtained an Associate's Degree in Science. She is not employed at this time. She last worked in 06/19 as a supervisor of office operations and held that job for 19 years before leaving due to health problems. She indicated that she had difficulty with organization on a problem and struggled to deal with other people.

LONGITUDINAL HISTORY:

PSYCHIATRIC HISTORY: The claimant has never been hospitalized for any psychiatric reasons. She has been in therapy in the past, but is not in therapy at this time.

MEDICAL HISTORY: The claimant was hospitalized in 2006 for tonsillectomy, in 2013 for removal of her gallbladder, in 2014 for bariatric surgery, and in 2019 for shoulder surgery. Chronic or current medical conditions include rheumatoid arthritis, Crohn's disease, enteropathic arthritis, high blood pressure, GERD, sleep apnea, fibromyalgia, lupus, and tremor in her left hand. Current medications: Alprazolam 0.25 mg 3 times a day, Wellbutrin 300 mg once a day, Effexor 225 mg once a day, folic acid 1 mg once a day, methotrexate every Saturday, Stelara 90 mg every 8 weeks, pantoprazole 40 mg once a day, Flexeril 10 mg 3 times a day, ondansetron 8 mg as needed, lisinopril 20 mg once a day, nitroglycerin ointment 0.4% twice a day, vitamin D3 1000 units once a day, estradiol once a day, and epinephrine 0.3 mg as needed.

BROWN, JENNIFER L
F190VMN

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08/21/2019
AMANDA SLOWIK, PSY.D.

CURRENT FUNCTIONING: The claimant has difficulty falling asleep due to pain and sleep apnea. She mentioned a loss of appetite and a weight loss of 10 lb over the last month. When asked about her mood, the claimant reported a low mood due to her chronic pain, physical limitations, and inability to work. She also stated that she has experienced stress associated with two recent losses of family members and has subsequently inherited their properties. This has resulted in conflict with other family members to the point where the claimant had to get a lawyer to manage the conflict. She endorsed depressive symptoms such as a low mood, crying spells, irritability, and social withdrawal, but denied suicidal or homicidal ideation. The claimant also mentioned feeling anxious in social situations and stated that she has a tendency to imagine the worst case scenario in many situations. Symptoms of anxiety include trembling, headaches, sweating, and exacerbation of her pre-existing pain. She did not endorse any symptoms of mania or a thought disorder. She did report problems with short-term memory, concentration, learning, organization, and planning.

DRUG AND ALCOHOL HISTORY: The claimant asserted that she has never used any drugs, alcohol, or cigarettes. She has never been in a substance abuse treatment program.

LEGAL HISTORY: She has no involvement with the legal system.

FAMILY HISTORY: Family history is significant for psychiatric and learning issues.

MILITARY HISTORY: The claimant has no involvement with the military.

MENTAL STATUS EXAMINATION: The claimant was cooperative. Her social skills were adequate.

APPEARANCE: She appeared her stated age. Her dress was appropriate and casual. She appeared well groomed. The claimant wore glasses to the evaluation today. Posture tense. Motor behavior restless. Eye contact appropriate.

BROWN, JENNIFER L
F190VMN

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08/21/2019
AMANDA SLOWIK, PSY.D.

SPEECH: Intelligibility fluent. Quality of voice was clear. Expressive and receptive language skills were adequate.

THOUGHT PROCESSES: Thought processes were coherent and goal directed with no evidence of hallucinations, delusions, or paranoia in the evaluation setting.

AFFECT: Anxious.

MOOD: Mood was reported to be dysthymic and anxious. The claimant rated her anxiety as an 8/10 today.

SENSORIUM: Clear.

ORIENTATION: The claimant was oriented to person, time, and place.

ATTENTION AND CONCENTRATION: Attention and concentration were mildly impaired. The claimant was able to count backwards from 10, do simple calculations, but struggled with the serial 7s and the serial 3s.

RECENT AND REMOTE MEMORY SKILLS: Recent and remote memory skills were mildly impaired. The claimant was able to remember 3 out of 3 objects immediately and 2 out of 3 objects after a five-minute delay. When given a hint about the category to which the third object belonged, the claimant was not able to produce the third object. She could recite 7 digits forward and 3 digits backwards. Worthy of note was the claimant rated her physical pain as a 7/10 today.

COGNITIVE FUNCTIONING: Intellectual functioning was likely in the average range. General fund of information appeared appropriate to experience.

INSIGHT: Good.

JUDGMENT: Good.

BROWN, JENNIFER L
F190VMN

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08/21/2019
AMANDA SLOWIK, PSY.D.

CONSISTENCY: The results of the mental status evaluation are consistent with the claimant's vocational history.

MODE OF LIVING: The claimant does dress, bathe, and groom herself with use of a grab bar. Her boyfriend brushes her hair. She does simple cooking and food preparation. Her boyfriend does most of the cleaning nowadays because of her pain. She does assist with laundry. She typically orders groceries online to avoid having to ambulate around the store. She does manage her own money with the assistance of her boyfriend. The claimant does drive. She is unsure whether or not she has access to a public bus. When asked about her social life, the claimant indicated that she has some supportive family members with whom she spends time and keeps in touch with friends. Hobbies and interests include watching TV.

MEDICAL SOURCE STATEMENT: The claimant's ability to understand, remember, or apply simple directions and instructions, maintain personal hygiene, and be aware of normal hazards is not limited. The claimant's ability to understand, remember, or apply complex directions and instructions and sustain concentration is mildly limited. The claimant's ability to interact adequately with supervisors, coworkers, and the public, sustain an ordinary routine, and regulate emotions is moderately limited. Difficulties are caused by distractibility, anxiety, and a low mood.

The results of the present evaluation appear to be consistent with psychiatric and cognitive problems, although it is unclear as to whether or not they are significant enough to interfere with the claimant's ability to function on a daily basis.

DIAGNOSIS:

Bereavement.
Unspecified anxiety disorder.

Medical diagnosis reported by the claimant: Please see medical conditions mentioned earlier in the report.

BROWN, JENNIFER L
F190VMN

-5-

08/21/2019
AMANDA SLOWIK, PSY.D.

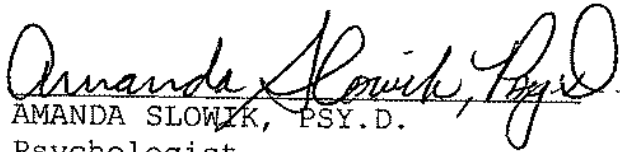
RECOMMENDATIONS: Individual psychological therapy, medical follow up and evaluation, vocational training and rehabilitation continue with psychiatric treatment.

EXPECTED DURATION OF IMPAIRMENT AND TIME FRAME FOR SUGGESTED THERAPY: Expected duration of impairment a year.

PROGNOSIS: Prognosis is fair.

ABILITY TO MANAGE FUNDS: The claimant will likely need assistance in managing her funds due to supported difficulties in this area.

The above-mentioned claimant was examined for a consultative examination. No doctor-patient relationship exists or is implied by this examination.


AMANDA SLOWIK, PSY.D.
Psychologist
Psychology

AS/OAK/04236//13532/2347123

Report Barcode

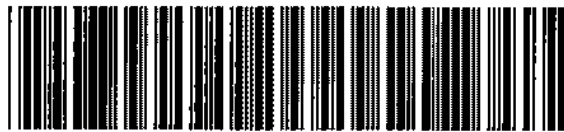
F190VMN

Client: New York State Disability

Claimant: JENNIFER L BROWN

Provider: Amanda Slowik

Date and Time: 8/21/2019, 10:30 AM



IMA99F190VMN

R

Industrial Medicine Associates, P.C.
Binghamton, New York

Claimant's Name: BROWN, JENNIFER L V/139/9749 F190VMP

Date: 08/21/2019

Provider's Name: GILBERT JENOURI, M.D.

ID#4316152

DOB: 10/26/1976

INTERNAL MEDICINE EXAMINATION

The claimant is a 42-year-old female referred by the Division of Disability Determination for an internal medicine examination.

CHIEF COMPLAINT: The claimant has a history of fibromyalgia and rheumatoid arthritis. She reports having joint discomfort all over. The claimant typically has pain in her neck and lower back described as sharp with intensity of 6/10. She says the pain radiates to her hips and her left shoulder.

She also has a history of Crohn's disease presently medically managed and stable.

The claimant has a history of obstructive sleep apnea presently on CPAP therapy.

She has hypertension diagnosed in 2008, diet controlled, no complications.

PAST HISTORY: She denies history of diabetes, heart attack, other heart disease, asthma, emphysema, and seizures. She was seen in the past at Robert Packer Hospital for shoulder surgery, in 2014, Robert Packer for bariatric sleeve, and in 2013, Robert Packer for gallbladder.

CURRENT MEDICATIONS:

1. Xanax 0.25 mg t.i.d.
2. Wellbutrin 300 mg q.d.
3. Effexor 225 mg q.d.
4. Folic acid 1 mg q.d.
5. Methotrexate 2 mL every week.
6. Stelara 90 mg every 8 weeks.
7. Protonix 40 mg q.d.

BROWN, JENNIFER L
F190VMP

-2-

08/21/2019
GILBERT JENOURI, M.D.

SOCIAL HISTORY: No tobacco, alcohol, or street drugs. She does not live alone.

ACTIVITIES OF DAILY LIVING: She does cooking twice a week, laundry once a week, shopping twice a week, showers and dresses every day, and watches TV. PCP is Dr. Gillen [sic].

PHYSICAL EXAMINATION:

HEIGHT: 5' 11" w/o shoes
WEIGHT: 277 lb w/o shoes
BP: 112/80 using an appropriately sized cuff
PULSE: 80 beats/minute
RESPIRATION: 16/minute

VISION: Right 20/20, Left 20/20, Both 20/15 on a Snellen chart at 20 feet with glasses.

GENERAL APPEARANCE, GAIT, STATION: The claimant appeared to be in no acute distress. Gait normal. Can walk on heels and toes with difficulty. Squat 50% of full. Stance normal. Used no assistive devices. Needed no help changing for exam or getting on and off exam table. Able to rise from chair without difficulty.

SKIN AND LYMPH NODES: Skin exam within normal limits. No significant adenopathy.

HEAD AND FACE: Head normocephalic. Head atraumatic. Facies normal.

EYES: Sclerae anicteric. Conjunctivae clear. PERRLA. EOMI. Fundi normal.

EARS, NOSE, AND THROAT: Ears normal. Nose normal. Throat normal. Teeth normal.

NECK: Supple, no masses. No JVD. No thyromegaly or bruits.

BROWN, JENNIFER L
F190VMP

-3-

08/21/2019
GILBERT JENOURI, M.D.

CHEST AND LUNGS: Normal AP diameter. Clear to auscultation. Percussion normal. No significant chest wall abnormality. Normal diaphragmatic motion.

HEART: Regular rhythm. PMI in left 5th intercostal space at midclavicular line. No murmur, gallop, or rub audible.

ABDOMEN: Bowel sounds normal. Abdomen soft with bilateral lower quadrant tenderness to palpation. No rebound. No hepatosplenomegaly or masses. No abdominal bruits.

MUSCULOSKELETAL: Cervical spine flexion 40 degrees, extension 30 degrees, lateral flexion 20 degrees bilaterally, and rotation 70 degrees bilaterally. No scoliosis, kyphosis, or abnormality in thoracic spine. Lumbar spine flexion 90 degrees, extension 20 degrees, lateral flexion 30 degrees bilaterally, and rotation 30 degrees bilaterally. SLR 70 degrees positive bilaterally, not confirmed seated. Shoulder forward elevation right 150 degrees and left 130 degrees, abduction right 150 degrees and left 100 degrees; adduction, internal rotation and external rotation full ROM bilaterally. Full ROM of elbows, forearms, and wrists bilaterally. Hip flexion/extension 80 degrees bilaterally; rotation, interior and exterior full ROM bilaterally, backward extension 20 degrees bilaterally, abduction 30 degrees bilaterally, and adduction 10 degrees bilaterally. Knee flexion/extension right full ROM and left 0-130 degrees. Ankle dorsiflexion and plantar flexion full ROM bilaterally. No evident subluxations, contractures, ankylosis, or thickening. Joints stable and nontender. No redness, heat, swelling, or effusion. Trigger points for fibromyalgia bilateral shoulders, lumbar area, and knees.

NEUROLOGIC: DTRs physiologic and equal in upper and lower extremities. No sensory deficit noted. Strength 5/5 in the upper and lower extremities.

EXTREMITIES: No cyanosis, clubbing, or edema. Pulses physiologic and equal. No significant varicosities or trophic changes. No muscle atrophy evident.

BROWN, JENNIFER L
F190VMP

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08/21/2019
GILBERT JENOURI, M.D.

FINE MOTOR ACTIVITY OF HANDS: Hand and finger dexterity intact. Grip strength 5/5 on the right and 4/5 on the left. She is able to zip, button, and tie.

LABS AND OTHER TESTING:

XRAY LEFT SHOULDER: *Key*

XRAY RIGHT HAND: *Key.*

DIAGNOSIS:

1. History of fibromyalgia.
2. Rheumatoid arthritis.
3. Joint pains.
4. Neck pain.
5. Low back pain.
6. Left shoulder pain.
7. Bilateral hip pain.
8. Crohn's disease.
9. Hypertension
10. Obstructive sleep apnea.

PROGNOSIS: Stable

MEDICAL SOURCE STATEMENT: Mild restriction walking and standing long periods, bending, stair climbing, lifting, and carrying.

The above-mentioned claimant was examined for a consultative examination. No doctor-patient relationship exists or is implied by this examination.



GILBERT JENOURI, M.D.
Internal Medicine

GJ/OAK/05001//15318/2348685

RADIOLOGY REPORT – THE IMA GROUP
679 MAIN ST.
JOHNSON CITY, NY 13790

Tuesday, August 27, 2019

Claimant: Brown, Jennifer L
Appt. ID: 4316152
DOB: 10/26/1976
Date of Examination: 8/21/2019
Radiologist: Joseph Gottesman MD

Hand, Right X-Ray Including Fingers (3 Views)

Presented for interpretation is a radiographic examination of the right hand.

Views of the right hand demonstrate no evidence of acute fracture, dislocation, or destructive bony lesion. The joint spaces are relatively well maintained.

Impression: No acute bony abnormality.



Reviewed and Electronically Signed by
Joseph Gottesman MD
Cert. American Board of Radiology

829-4



RADIOLOGY REPORT – THE IMA GROUP
679 MAIN ST.
JOHNSON CITY, NY 13790

Tuesday, August 27, 2019

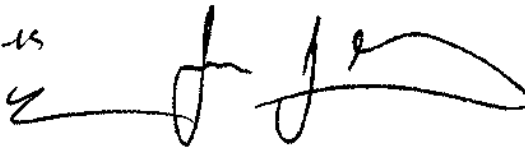
Claimant: Brown, Jennifer L.
Appt. ID: 4316152
DOB: 10/26/1976
Date of Examination: 8/21/2019
Radiologist: Joseph Gottesman MD

Shoulder, Left X-Ray 2 Views

Presented for interpretation is a radiographic examination of the left shoulder.

There is no evidence of acute fracture, dislocation, or destructive bony lesion. The joint spaces are relatively well maintained.

Impression: No acute bony abnormality.

8-24-19


Reviewed and Electronically Signed by
Joseph Gottesman MD
Cert. American Board of Radiology

Report Barcode

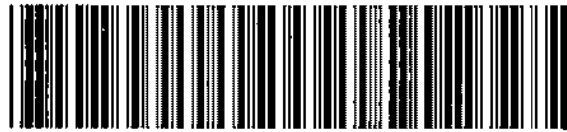
F190VMP

Client: New York State Disability

Claimant: JENNIFER L BROWN

Provider: Gilbert Jenouri

Date and Time: 8/21/2019, 9:45 AM



IMA99F190VMP

R

EXHIBIT NO. B9F
PAGE: 1 OF 4



NYS Office of Temporary and Disability
Assistance, Division of Disability
Determinations
K. RICHARDSON
PO Box 8783
London, KY 40742-9927

03190819000119

TX#6020-72842

****Please send all available medical records including imaging, diagnostics testing, from 06/19/2017 to present. Formerly known as Jennifer Lyn Evans. . Thank you.****

Patient ID Number: Date of Last Exam:

Frequency of Treatment: Date First Seen:

Height: Weight:

Blood Pressure, Most Recent, Significant Changes Noted:

Treating Diagnoses:

Please indicate current symptoms:

Treatment and Response:

Please include medications prescribed with dosage and frequency, side effects, and any surgical procedures performed:

Please indicate the expected duration and prognosis of the claimant's condition:

If your patient has displayed any behavior suggestive of a significant psychiatric disorder, please describe (with dates):

If weight loss, please provide representative weights over at least a 3 month period and comment on expected persistence:

Past and present symptoms with dates and severity (i.e., pain, hemorrhage, jaundice, anorexia, ascites, nausea, vomiting, diarrhea, weakness, arthritis, iritis, fever etc):

Laboratory Findings:

Please include chest x-rays, angiography, catheterization, echocardiography, contrast, or radio-isotopic ventriculography (with dates):

In cases of peripheral arterial disease, please give results of arteriography, plethysmography, or Doppler. (If Doppler exercise studies were performed, indicate speed and grade of treadmill, duration, symptoms, systolic BPs before and after exercise and time required for return to pre-exercise systolic BP.)

Describe any limitations of physical activity as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity; include specific symptoms and resulting limitations.

Based on the medical findings provided in my report, my medical opinion regarding this individual's ability to do work-related physical activities is as follows:

- Lift and Carry
 - ☐ No Limitation ☐ Limited (Please specify both below)
 - ☐ Occasionally (up to 1/3 of a work day): lbs.
 - ☐ Frequently (up to 2/3 of a work day): lbs.
 - Maximum number of pounds that can be lifted and carried is: lbs.
- Stand and/or Walk
 - ☐ No Limitation ☐ Limited (please check extent below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Up to 2 hours per day ☐ Less than 2 hours per day
- Sit
 - ☐ No Limitation ☐ Limited (please check one below)
 - ☐ Up to 8 hours per day ☐ Up to 6 hours per day
 - ☐ Less than 6 hours per day
- Push and/or Pull (including hand & foot controls)
 - ☐ No Limitation ☐ Limited (please specify below)
 - ☐ Upper extremities (please describe)
- Other (e.g. postural, manipulative, visual, communicative, environmental)
 - ☐ No Limitation ☐ Limited (please describe below)

☐ I cannot provide a medical opinion regarding this individual's ability to do work-related activities.

Are there any other conditions significant to recovery? ☐ No ☐ Yes

- If yes, please record your comments below. (If necessary, the reverse of this page may be used.)

Please indicate the best days and times for us to call if we need to ask for additional or clarifying information. Day: Time:

Facility _____ Phone _____

Signature _____ Title _____

Name Printed _____ Date _____

031908190000119

ELECTRONIC REQUEST FOR MEDICAL ADVICE

Case Surname JENNIFER L. BROWN SSN 132-58-2507

1. From Unit V139 Analyst (Signature) Richardson, K.

MC Specialty Required *INITIALS* *DATE*

2. Referred to Med Consultant _____

3. Advice prepared: case file returned to originating Analyst M.C.
named above in item 1.

4. Description of problem: (See notes below regarding cardiac cases)

☐ Analysis of ECG tracing, see reverse

☒ Other (Describe)

This 42.8 y/o F alleges disability under Title II due to rheumatoid arthritis, Crohn's disease, and mental health complaints.

She has also recently had a left shoulder arthroscopic decompression and distal clavicle excision as well as a diagnosis of fibromyalgia. Her Crohn's appears well controlled at this time.

Please see proposed RFC in eCat for 12 months after AOD. Review, amend as appropriate, and sign.
Thank you.

5. Advice:

RFC signed. Thank you.

☐ Exercise ECG. I have not examined this claimant. I have read the claimant's case file and I can find no evidence which place the claimant at significant risk during the performance of an ET. The determination to proceed with an ET, however, rests with the physician performing the consultative examination.

(Signature)

(Date)

Review Physician Analysis

6. Source _____ 7. Date(s) _____

8. Type of ECG _____ (See Note 1 on reverse)

9.

a. Technically Correct ☐ Yes ☐ No *If no, explain in item 11*b. Standardized ☐ Yes ☐ No *If no, explain in item 11*c. Claimant taking ECG – altering drugs ☐ Yes ☐ No *If no, explain in item 11*

10. Tracing is normal, or

11. Abnormalities noted:

12. Conclusion:

13. Koenig, J. _____ 9/9/19 _____
(Signature) (Date)

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

**Summarization of Episode Note
Continuity of Care Document**

Received From: Guthrie Health System

MEGAHIT sent a request for electronic medical records from the following claimant-provided source(s):

Source Type: Doctor/Therapist
Source Name: Guthrie Clinic
Address: One Guthrie Square
Sayre, PA 18840
Voice Phone: 570-887-2482

Source Type: Doctor/Therapist
Source Name: Guthrie Clinic
Address: One Guthrie Square
Sayre, PA 18840
Voice Phone: 570-887-2852

Source Type: Doctor/Therapist
Source Name: Guthrie Clinic
Address: One Guthrie Square
Sayre, PA 18840
Voice Phone: 570-887-2239

Source Type: Doctor/Therapist
Source Name: Guthrie Clinic
Address: One Guthrie Square
Sayre, PA 18840
Voice Phone: 570-887-2852

Source Type: Doctor/Therapist
Source Name: Guthrie Clinic
Address: One Guthrie Square
Sayre, PA 18840
Voice Phone: 570-887-2852

Creation Date:
10/24/2019

Date Range Requested:
06/27/2019 - 10/24/2019

Type of Request:
MEGAHIT Triggered

Jennifer Lyn Brown
SSN: 132-58-2507

DOB: 10/26/1976

Sex: Female

Partner Medical Record Demographics:

Name: Jennifer Lyn Brown

DOB: 10/26/1976

Sex: Female

Table of Contents

- Problems List [PROB LIST]
- Encounters [ENC]
- Procedures [PROCED]
- Laboratory Results [LABS]
- Vital Signs [VITALS]
- Medication Information [MEDS]
- Plan of Care [CARE PLAN]
- Healthcare Providers [PROV LIST]

PROB LIST

Problems List

<u>Problem [Code]</u>	<u>Occurrences</u>	<u>First Date</u>	<u>Last Date</u>	<u>Associated Types</u>	<u>Last Prognosis Value</u>	<u>Last Prognosis Date</u>
Acute atopic conjunctivitis, bilateral [H10.13] Chr allrg conjunctiv NEC [372.14] Allergic conjunctivitis of both eyes [809289] Fibromyalgia [M79.7] Myalgia and myositis NOS [729.1] Fibromyalgia [44098]	1	09/13/2019	-	Disease		
Impingement syndrome of left shoulder [M75.42] Shoulder region dis NEC [726.2] Impingement syndrome of left shoulder [1584121]	1	08/20/2014	-	Disease		
Myopia, bilateral [H52.13] Myopia [367.1] Myopia of both eyes [1619756]	1	03/01/2019	-	Disease		
Other long term (current) drug therapy [Z79.899] Long-term use meds NEC [V58.69] Long term current use of immunosuppressive drug [63735183]	1	06/27/2017	-	Disease		
Arthralgia of the upper arm [267950000] Pain in unspecified elbow [M25.529] Joint pain-up/arm [719.42] Pain in joint, upper arm [82717]	1	12/27/2016	-	Disease		
Attention deficit hyperactivity disorder [406506008] Attention-deficit hyperactivity disorder, unspecified type [F90.9] Attn deficit w hyperact [314.01] ADHD (attention deficit hyperactivity disorder) [193722]	1	10/30/2018	-	Disease		
Benign hypertension [10725009] Essential (primary) hypertension [I10]	1	12/28/2012	-	Disease		
	1	10/07/2008	-	Disease		

Benign hypertension [401.1] HTN (hypertension), benign [514387]				
Chronic sinusitis [40055000] Chronic sinusitis, unspecified [J32.9] Chronic sinusitis NOS [473.9] Unspecified sinusitis (chronic) [56546]	1	05/23/2005	-	Disease
Cobalamin deficiency [190634004] Deficiency of other specified B group vitamins [E53.8] B-complex defic NEC [266.2] Vitamin B12 deficiency [56922]	1	02/09/2017	-	Disease
Crohn's disease [34000006] Crohn's disease, unspecified, without complications [K50.90] Regional enteritis NOS [555.9] Crohn's disease [41297]	1	07/08/2016	-	Disease
Depressive disorder [35489007] Major depressive disorder, single episode, unspecified [F32.9] Depressive disorder NEC [311] Depression [41696]	1	01/20/2014	-	Disease
Dry eyes [162290004] Dry eye syndrome of bilateral lacrimal glands [H04.123] Tear film insuffic NOS [375.15] Bilateral dry eyes [1723793]	1	06/27/2017	-	Disease
Enteropathic arthritis [9350004] Enteropathic arthropathies, unspecified site [M07.60] Arthrop w noninf GI dis [713.1] Enteropathic arthritis [1412]	1	07/17/2019	-	Disease
Environmental allergy [426232007] Other allergy status, other than to drugs and biological substances [Z91.09] Hx-allergy NEC [V15.09] Environmental allergies [602827]	1	01/05/2014	-	Disease

Eruption due to drug [28926001] Generalized skin eruption due to drugs and medicaments taken internally [L27.0] Drug dermatitis NOS [693.0] Drug eruption [41806]	1	11/23/2016	-	Disease
Eruption [271807003] Rash and other nonspecific skin eruption [R21] Nonspecif skin erupt NEC [782.1] Rash [43543]	1	12/05/2016	-	Disease
Eyelid finding [246812007] Fasciculation [R25.3] Abn involun movement NEC [781.0] Eyelid twitch [815440]	1	04/22/2019	-	Disease
Finding of movement of hand [299041004] Tremor, unspecified [R25.1] Abn involun movement NEC [781.0] Tremor of left hand [50993262]	1	03/15/2016	-	Disease
Gastroesophageal reflux disease [235595009] Gastro-esophageal reflux disease without esophagitis [K21.9] Esophageal reflux [530.81] GERD (gastroesophageal reflux disease) [72350]	1	10/07/2008	-	Disease
Generalized anxiety disorder [21897009] Generalized anxiety disorder [F41.1] Generalized anxiety dis [300.02] GAD (generalized anxiety disorder) [313428]	1	10/22/2010	-	Disease
Hereditary essential tremor [609559001] Essential tremor [G25.0] Tremor NEC [333.1] Benign head tremor [1044223]	1	03/15/2016	-	Disease
History of bariatric surgical procedure [608848006] Bariatric surgery status [Z98.84] Bariatric surgery status [V45.86] Status post bariatric surgery [525410]	1	12/26/2014	-	Disease
Inflammatory	1	08/09/2016	-	Disease

neuropathy [21018002] Neuralgia and neuritis unspecified [M79.2] Neuralgia/neuritis NOS [729.2] Neuritis [50625]				
Multiple benign melanocytic nevi [402555001] Melanocytic nevi, unspecified [D22.9] Benign neoplasm skin NOS [216.9] Multiple benign nevi [5724378]	1	08/09/2016	-	Disease
Non-toxic multinodular goiter [36241006] Nontoxic multinodular goiter [E04.2] Nontox multinodul goiter [241.1] Nontoxic multinodular goiter [45270]	1	01/18/2011	-	Disease
Obesity [414916001] Obesity, unspecified [E66.9] Obesity NOS [278.00] Obesity [92278]	1	10/22/2010	-	Disease
Obstructive sleep apnea syndrome [78275009] Obstructive sleep apnea (adult) (pediatric) [G47.33] Obstructive sleep apnea [327.23] Severe obstructive sleep apnea [25715530]	1	06/10/2013	-	Disease
Patient encounter status [305058001] Encounter for therapeutic drug level monitoring [Z51.81] Therapeutic drug monitor [V58.83] Therapeutic drug monitoring [818990]	1	05/02/2017	-	Disease
Plantar fascial fibromatosis [13370002] Plantar fascial fibromatosis [M72.2] Plantar fibromatosis [728.71] Plantar fascial fibromatosis [1981]	1	09/09/2004	-	Disease
Primary focal hyperhidrosis [427794001] Generalizd hyperhidrosis [780.8]	1	05/24/2010	-	Disease
Rheumatoid arthritis [69896004] Rheumatoid arthritis, unspecified [M06.9] Rheumatoid arthritis [714.0] Rheumatoid arthritis	1	12/12/2008	-	Disease

Senile angioma

[5050001]

Nevus, non-neoplastic

[I78.1]

Hemangioma skin

[228.01]

Cherry angioma

[960835]

Solar degeneration

1

08/09/2016

-

Disease

[43982006]

Other skin changes
due to chronic
exposure to
nonionizing radiation
[L57.8]

Oth dermatitis solar
rad [692.79]

Sun-damaged skin
[800593]

Vitamin D deficiency

1

02/09/2017

-

Disease

[34713006]

Vitamin D deficiency,
unspecified [E55.9]

Vitamin D deficiency
NOS [268.9]

Vitamin D deficiency
[88575]

Narrative Text

Problem

Noted Date

Allergic conjunctivitis of both eyes

09/13/2019

Enteropathic arthritis

07/17/2019

Eyelid twitch

04/22/2019

Impingement syndrome of left shoulder

03/01/2019

Overview:

Added automatically from request for surgery 425306

Pain in joint, upper arm

10/30/2018

Myopia of both eyes

06/27/2017

Bilateral dry eyes

06/27/2017

Therapeutic drug monitoring

05/02/2017

Vitamin D deficiency

02/09/2017

Vitamin B12 deficiency

02/09/2017

Long term current use of immunosuppressive drug

12/27/2016

Rash

12/05/2016

Drug eruption

11/23/2016

Overview:

likely, Remicade vs Wellbutrin

Multiple benign nevi

08/09/2016

Cherry angioma

08/09/2016

Sun-damaged skin

08/09/2016

Neuritis

08/09/2016

Overview:

on palms

Crohn's disease

07/08/2016

Tremor of left hand

03/15/2016

Benign head tremor

03/15/2016

Status post bariatric surgery

12/26/2014

Fibromyalgia

08/20/2014

Depression

01/20/2014

Environmental allergies

01/05/2014

Severe obstructive sleep apnea

06/10/2013

ADHD (attention deficit hyperactivity disorder)

12/28/2012

Nontoxic multinodular goiter

01/18/2011

Obesity	10/22/2010
Overview:	Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 869 of 1112
Body mass index is 38.53 kg/(m^2).	EXHIBIT NO. B11F
GAD (generalized anxiety disorder)	PAGE: 8 OF 57
Overview:	10/22/2010
On Paxil 40mg daily	
Hyperhydrosis disorder	05/24/2010
Rheumatoid arthritis	12/12/2008
Overview:	
Sees Dr. Freeman in Elmira.	
HTN (hypertension), benign	10/07/2008
GERD (Gastroesophageal Reflux Disease)	10/07/2008
Unspecified sinusitis (chronic)	05/23/2005
Overview:	
CT 2005	
Plantar fascial fibromatosis	09/09/2004

ENC

Encounters

Date	Type	Specialty	Care Team	Description
10/16/2019	Hospital Encounter		Traverso, Jose, DPT	Repeat Series
Robert Packer Hospital				
10/16/2019				
Progress Notes - Traverso, Jose, DPT - 10/16/2019 12:07 PM EDT				
Formatting of this note might be different from the original.				
The Guthrie Clinic				
Discharge Note				
Outpatient Physical Therapy Services				
ROBERT PACKER HOSPITAL				
RPH PHYSICAL THERAPY				
1 GUTHRIE SQUARE				
SAYRE PA 18840-1625				
Tel 570-887-4801				
Fax 570-887-5830				
Treatment Number: 6				
Discharge note from 9/17/19 to 10/16/19				
Referring Physician: Michael F Gillan				
Primary Diagnosis:				
ICD-9-CM ICD-10-CM				
1. Impingement syndrome of left shoulder 726.2 M75.42				
2. Left elbow pain 719.42 M25.522				
Time In: 1210				
Time Out: 1230				
Total Session Minutes: 20				
Pain at Start of Care: 1/10				
Pain at End of Care: 1/10				

Subjective Comments: General improvement from initial encounter. Improved tolerance to carrying groceries, overhead

Interventions:

EXHIBIT NO. B11F
PAGE: 9 OF 57

Manual **Therapy** (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance. MET to promote left shoulder flexion. Left median and radial pumps/glides ni supine.

Total Minutes (All Manual **Therapy**): 20

Objective:

No significant deformity to superficial exam. No increased temperature, no swelling, redness or echymossis observed. Significant cervico-thoracic postural dysfunction: forward cervical spine, hyphotic, prominent CTJ. Dermatomal exam C1-T1 to superficial pin/prick does not reveal sensory dysfunction. Deep Tendon Reflexes (bicipital, tricipital, brachioradialis) equal and symmetric, graded +2. Left shoulder ROM does not reveal significant restrictions or crepitus in all planes. Left shoulder Muscle Testing does not reveal significant weakness. No significant restriction observed during the exam of gleno-humeral, acromio-clavicular, sterno-clavicular or scapulo-thoracic joints.

Goals: All goals achieved

Pain: Patient will report decrease in left shoulder pain to 2/10 or less when performing overhead activities, vacuuming, left sidelying.

Posture: Patient will demonstrate good awareness of proper sitting posture without cuing from therapist.

Able to lift her dog (<20 lbs) without significant left shoulder pain

Assessment: Essentially normal left shoulder exam. Improved left shoulder AROM and tolerance to overhead activity. Improved general mobility, pain response to **ADLs**.

D/C at this time. Continue HEP prn.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 20

Total Treatment Minutes: 20

Author: Jose Traverso, DPT 10/16/2019 12:29

Electronically signed by Traverso, Jose, DPT at 10/16/2019 12:31 PM EDT

Hospital Encounter

Traverso, Jose, DPT

Repeat Series

Robert Packer Hospital

10/10/2019

Progress Notes - Traverso, Jose, DPT - 10/10/2019 3:30 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic

Treatment Note

Outpatient Physical **Therapy** Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL **THERAPY**

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

Tel 570-887-4801

Fax 570-887-5830

Treatment Number: 5

Referring Physician: Michael F Gillan

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42

2. Left elbow pain 719.42 M25.522

Time In: 1530

Time Out: 1600

Total Session Minutes: 30

Subjective Comments: Improved left shoulder mobility, tolerance to reaching. RA flare up, changing medication.
Better after today's encounter.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 7
Total Minutes (all Therapeutic Exercise): 25

Exercise #1

Exercise Name: Supine AA left shoulder flexion, progressed to manually resisted ER
Reason for Exercise: Joint Mobility
Location/Body Area: Shoulder;Left
Sets/Reps: 3x8 ea
Resistance: manual resistance

Exercise #2

Exercise Name: Seated Row
Reason for Exercise: Strengthening
Location/Body Area: Thoracic Spine;Shoulder
Sets/Reps: 3x10
Resistance: green TB

Exercise #3

Exercise Name: Supine shoulder flexion WAND
Reason for Exercise: Flexibility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10

Exercise #4

Exercise Name: Wall push ups
Reason for Exercise: Strengthening
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10

Exercise #5

Exercise Name: Wall slides
Reason for Exercise: Joint Mobility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 2x10

Exercise #6

Exercise Name: Scapular unilateral retraction
Reason for Exercise: Strengthening
Location/Body Area: Left;Shoulder
Sets/Reps: 2x10
Resistance: green TB

Exercise #7

Exercise Name: Bilateral shoulder ER
Reason for Exercise: Strengthening
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 2x10
Resistance: green TB

Assessment: Patient demonstrates improved left shoulder AROM, tolerance to overhead activities. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments including sustained overhead activities.

Plan for Next Visit: Physical **therapy** intervention will emphasize therapeutic exercise, neuromuscular re-education, manual **therapy**, modalities to control pain as deemed appropriate.
Anticipate D/C next encounter.

Author: Jose Traverso, DPT 10/10/2019 15:55

Electronically signed by Traverso, Jose, DPT at 10/10/2019 4:00 PM EDT

Hospital Encounter

Traverso, Jose, DPT

Repeat Series

Robert Packer Hospital
10/03/2019

Progress Notes - Traverso, Jose, DPT - 10/03/2019 12:33 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 4

Referring Physician: Michael F Gillan

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42
2. Left elbow pain 719.42 M25.522

Time In: 1230

Time Out: 1300

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: Patient reports sickness for the last week, non contagious at this time. Reports improvement left shoulder condition from initial encounter, able to lie on her left side without significant pain.
No worse after today's encounter.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 5
Total Minutes (all Therapeutic Exercise): 25

Exercise #1

Exercise Name: Supine AA left shoulder flexion, progressed to manually resisted ER
Reason for Exercise: Joint Mobility
Location/Body Area: Shoulder;Left
Sets/Reps: 3x10 ea
Resistance: manual resistance

Exercise #2

Exercise Name: Seated Row
Reason for Exercise: Strengthening
Location/Body Area: Thoracic Spine;Shoulder
Sets/Reps: 3x10
Resistance: green TB

Exercise #4
Exercise Name: Wall push ups
Reason for Exercise: Strengthening
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10

Exercise #5
Exercise Name: Wall slides
Reason for Exercise: Joint Mobility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 2x10

Unrestricted left shoulder AROM, minimal endrange flexion restriction. Absent significant left shoulder weakness in all planes.

Assessment: Patient demonstrates improved left shoulder mobility and muscular response to activity. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments including sustained housekeeping activities involving vacuuming and cleaning dishes.

Plan for Next Visit: Physical **therapy** intervention will emphasize therapeutic exercise, neuromuscular re-education, manual **therapy**, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 25
Total Treatment Minutes: 25

Author: Jose Traverso, DPT 10/3/2019 13:17

Electronically signed by Traverso, Jose, DPT at 10/03/2019 1:20 PM EDT
Office Visit Ripic, Shelli, CRNP

Visit for screening mammogram
(Primary Dx)

SAYRE

10/03/2019

Progress Notes - Ripic, Shelli, CRNP - 10/03/2019 11:00 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 10/3/2019

Subjective

SUBJECTIVE:

Jennifer Lyn Brown is 42-y.o. female who presents for routine women's health maintenance. Patient reports no gynecologic complaints. Cycles monthly with limited flow.

The patient denies abdominal or flank pain, anorexia, n/v or dysphagia, change in BM or black/bloody stools or weight loss. History of crohn's, has loose stool.

She denies abnormal vaginal bleeding, discharge, unusual pelvic pain. On oral contraceptive pill for contraception. Plans tubal removal.

Denies dysuria, frequency/urgency or hematuria.

Patient denies any exertional chest pain, dyspnea, palpitations, or edema. History of arthritis. Has some difficulty with activity. There is no personal history of breast **cancer**. She denies new lumps, breast pain or nipple discharge.

Nursing Notes:

Simmons, Mary 10/3/2019 11:08 AM Signed

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 10/3/2019

Chief Complaint

Patient presents with

- Annual

MENARCHE - 13 y/o
CONTRACEPTION - OCP
LAST PAP - 4.5.18
MAMMO - 6.26.19
DEXA - N/A
COLONOSCOPY - 6.11.18

Author: Mary Simmons 10/3/2019 11:00

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
- Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR

- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2014
- with liver **biopsy**
- PR CLOSED RX TARSAL FX,EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014
- for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
- PR SHLDR ARTHROSCOP,PART ACROMIOPLAS Left 5/24/2019
- Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR
- TONSILLECTOMY 11/26/07

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg.
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab Take 1 Tab by mouth EVERY BEDTIME.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- [START ON 10/5/2019] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 0.5 mL beneath the skin

EVERY SATURDAY.

- ondansetron (ZOFIRAN CD) 16 MG Oral Tablet DISPENSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated

Spouse name: Not on file

- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 standard drinks

- Drug use: No
- Sexual activity: Yes

Partners: Male

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

- Physical activity:

Days per week: Not on file

Minutes per session: Not on file

- Stress: Not on file

Relationships

- Social connections:

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

• Intimate partner violence:
Fear of current partner: Not on file
Emotionally abused: Not on file
Physically abused: Not on file
Forced sexual activity: Not on file
Other Topics Concern
• Not on file
Social History Narrative
August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

All remaining **review of systems** was negative except for as noted in the history of present illness/subjective.

Objective

PHYSICAL EXAMINATION:

VITALS: BP 140/90 | Ht 5' 11" (1.803 m) | Wt 281 lb 6.4 oz (127.6 kg) | LMP 09/05/2019 | BMI 39.25 kg/m² Body mass index is 39.25 kg/m².

GENERAL: alert, oriented, no acute distress.

NECK: no mass, no adenopathy, no thyromegaly.

LUNGS: clear to auscultation bilaterally.

HEART: regular rhythm, no murmurs.

EXTREMITIES: no clubbing, cyanosis, or edema.

BREAST: Inspection negative. No nipple discharge or bleeding. No masses or tenderness. No axillary nodes or masses..

ABDOMEN: soft, non tender, without masses or organomegaly.

BACK: negative.

PELVIC: labia: normal, vagina: No prolapse or lesions, Vaginal **findings** are normal except for:, Atrophic appearing mucosa which is pale and dry., cervix: Cervix is normal to inspection and without discharge., uterus: anteverted, mobile, non-tender, adnexa: No mass, fullness, tenderness.

ASSESSMENT:

ICD-9-CM ICD-10-CM

1. Visit for screening mammogram V76.12 Z12.31 MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Plan

PLAN:

All questions answered..

Will call for appointment with MD for tubal removal.

Plans to continue her oral contraceptive pill until that time.

Follow-up 12 months.

Author: Shelli Ripic, CRNP 10/3/2019 11:35

Electronically signed by Ripic, Shelli, CRNP at 10/03/2019 11:36 AM EDT

Nursing Note - Simmons, Mary - 10/03/2019 11:00 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 10/3/2019

Chief Complaint

Patient presents with

• Annual

MENARCHE - 13 y/o

CONTRACEPTION - OCP

LAST PAP - 4.5.18

MAMMO - 6.26.19

DEXA - N/A

COLONOSCOPY - 6.11.18

Author: Mary Simmons 10/3/2019 11:00

Electronically signed by Simmons, Mary at 10/03/2019 11:08 AM EDT

Office Visit

Freeman, James, MD

Rheumatoid arthritis involving both

• Intimate partner violence:
Fear of current partner: Not on file
Emotionally abused: Not on file
Physically abused: Not on file
Forced sexual activity: Not on file
Other Topics Concern
• Not on file
Social History Narrative
August 2016: Works at Guthrie GI department. Lives with husband, has no children.

SAYRE
10/02/2019

Progress Notes - Avetisova, Mariam, MD - 10/02/2019 3:40 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
 MRN: 340616
 DOB: 10/26/1976
 DATE OF SERVICE: 10/2/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with
 • Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.
 HPI

Jennifer Lyn Brown is a 42-y.o. female. with PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humira after she developed skin rash and allergy to remicade. Of note, patient developed drug induced lupus on Humira, and then changed to Ustekinumab by GI, methotrexate 25mg SC Q weekly. She states that she has widespread musculoskeletal pain involving the upper back and spine, neck, shoulders and the lower back and spine (including the buttocks), associated with fatigue and sleep disturbances. Her Crohn's symptoms have been well controlled. Recent ESR was normal.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father

Marfan syndrome

- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle

Aortic Dissection, Marfan's Syndrome

- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg.
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab Take 1 Tab by mouth EVERY BEDTIME.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- [START ON 10/5/2019] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 0.5 mL beneath the skin EVERY SATURDAY.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days

Current Facility-Administered Medications
Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated

Spouse name: Not on file

- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 standard drinks

- Drug use: No
- Sexual activity: Yes

Partners: Male

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

- Physical activity:

Days per week: Not on file

Minutes per session: Not on file

- Stress: Not on file

Relationships

- Social connections:

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

- Intimate partner violence:

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

ROS

A full 12 point **review of systems** was negative or as noted in the History of Present Illness.**Objective**

PHYSICAL EXAM:

VITALS: BP 118/72 | Ht 5' 11" (1.803 m) | Wt 278 lb (126.1 kg) | LMP 09/05/2019 | BMI 38.77 kg/m² Body mass index is 38.77 kg/m².

Physical Exam

HENT:

Head: Normocephalic and atraumatic.

Nose: Nose normal.

Eyes:

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Neck:

Musculoskeletal: Normal range of motion and neck supple.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Heart sounds: Normal heart sounds. No murmur.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing or rales.

Chest:

Chest wall: No tenderness.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no tenderness.

Musculoskeletal: Normal range of motion.

General: Tenderness present. No swelling, deformity or signs of injury.

Right lower leg: No edema.

Left lower leg: No edema.

Comments: Tenderness on palpation of upper, lower back, shoulders, knees, hips, neck

Skin:

General: Skin is warm and dry.

Neurological:

Mental Status: She is alert and oriented to person, place, and time.

Deep Tendon Reflexes: Reflexes are normal and symmetric.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) 714.0 M05.731 M05.732
2. Enteropathic arthritis 713.1 M07.60
3. Fibromyalgia 729.1 M79.7

Plan

Fibromyalgia in a patient with a hx of enteropathic arthritis:

Pt presented with widespread musculoskeletal pain involving the upper back and spine, neck, shoulders and the lower back and spine (including the buttocks), associated with fatigue and sleep disturbances.

Will start amitriptyline 25 mg QHS, will increase Sulfasalazine to 3 tabs BID

C/w Ustekinumab

Will decrease Methotrexate to 0.5 MI Q7 days for 4 weeks as her enteropathic arthritis is reasonable well controlled

Patient instructions:

Please decrease methotrexate to 0.5 MI for 4 weeks

START taking amitriptyline 25 mg before bedtime

Continue with stelara

Increase sulfasalazine to 3 tabs twice daily

Follow up in 2 months

Electronically signed by Avetisova, Mariam, MD at 10/04/2019 10:46 AM EDT

Progress Notes - Freeman, James, MD - 10/02/2019 3:40 PM EDT

I saw and evaluated the patient. Discussed with resident and agree with the resident's **findings** and plan as documented in the resident's note.

James Freeman, MD
Supervising physician

Electronically signed by Freeman, James, MD at 10/15/2019 10:23 AM EDT

Hospital Encounter

Traverso, Jose, DPT

Repeat Series

Robert Packer Hospital

09/23/2019

Progress Notes - Traverso, Jose, DPT - 09/23/2019 1:40 PM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 3

Referring Physician: Michael F Gillan

Primary **Diagnosis**:

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42
2. Left elbow pain 719.42 M25.522

Time In: 1330

Time Out: 1400

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: At admission patient reports left elbow and shoulder pain during **ADLs**, taking care of her mother, playing on her phone and computer. Denies acute or constitutional symptoms. Patient reports left elbow and shoulder likely related to cleaning at home, phone and computer entertainment.
No worse after today's encounter.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 3
Total Minutes (all Therapeutic Exercise): 15

Exercise #1
Exercise Name: Standing bilateral shoulder extension
Reason for Exercise: Joint Mobility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10
Resistance: red TB

Exercise #2
Exercise Name: Seated Row
Reason for Exercise: Strengthening
Location/Body Area: Thoracic Spine;Shoulder
Sets/Reps: 3x10
Resistance: red TB

Exercise #3
Exercise Name: Supine shoulder flexion WAND
Reason for Exercise: Flexibility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10

Manual **Therapy** (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance. MET to promote left shoulder flexion. Left median and radial pumps/glides ni supine.

Total Minutes (All Manual **Therapy**): 10

Unrestricted left shoulder AROM in all planes. Absent significant left shoulder or elbow weakness.

Assessment: Unspecific left shoulder and elbow pain complaints triggered by daily activity involving playing with her computer and phone, housekeeping. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments including overhead activities, vacuuming, cooking.

Plan for Next Visit: Physical **therapy** intervention will emphasize therapeutic exercise, neuromuscular re-education, manual **therapy**, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 25
Total Treatment Minutes: 25
Author: Jose Traverso, DPT 9/23/2019 15:04

Electronically signed by Traverso, Jose, DPT at 09/23/2019 3:06 PM EDT

Hospital Encounter

Traverso, Jose, DPT

Repeat Series

Robert Packer Hospital

09/19/2019

Progress Notes - Traverso, Jose, DPT - 09/19/2019 10:04 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Treatment Note
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 2

Referring Physician: Michael F Gillan

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42
2. Left elbow pain 719.42 M25.522

Time In: 1000

Time Out: 1030

Total Session Minutes: 30

Pain at Start of Care: 3/10

Subjective Comments: Soreness at admission, reports ability to perform HEP without significant pain.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 3
Total Minutes (all Therapeutic Exercise): 15

Exercise #1
Exercise Name: Thoracic extension in sitting and standing position during expiration
Reason for Exercise: Joint Mobility
Location/Body Area: Thoracic Spine
Sets/Reps: 2x5

Exercise #2
Exercise Name: Seated Row
Reason for Exercise: Strengthening
Location/Body Area: Thoracic Spine;Shoulder
Sets/Reps: 3x10
Resistance: red TB

Exercise #3
Exercise Name: Seated shoulder flexion WAND
Reason for Exercise: Flexibility
Location/Body Area: Bilateral;Shoulder
Sets/Reps: 3x10

Manual **Therapy** (97140)
Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance. MET to promote left shoulder flexion. Left median and radial pumps/glides ni supine.
Total Minutes (All Manual **Therapy**): 10

Unrestricted left shoulder AROM, absent significant mechanical **findings**.

Assessment: Patient demonstrates fair tolerance to exercise activity, fair adherence to HEP. Skilled Physical **Therapy** services are required to address ongoing functional and **objective** limitations/impairments including sustained physical activities involving reaching overhead, carrying groceries, house keeping.

Plan for Next Visit: Physical **therapy** intervention will emphasize therapeutic exercise, neuromuscular re-education, manual **therapy**, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:
Total TIMED Code Treatment Minutes: 25
Total Treatment Minutes: 25

Author: Jose Traverso, DPT 9/19/2019 10:41

Electronically signed by Traverso, Jose, DPT at 09/19/2019 10:41 AM EDT
Hospital Encounter Traverso, Jose, DPT

Repeat Series

Robert Packer Hospital
09/17/2019

Progress Notes - Traverso, Jose, DPT - 09/17/2019 10:43 AM EDT

Formatting of this note might be different from the original.

The Guthrie Clinic
Initial Evaluation
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 9/17/2019

EXHIBIT NO. B11F
PAGE: 24 OF 57

Referring Physician: Michael F Gillan

Primary **Diagnosis:**

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42

2. Left elbow pain 719.42 M25.522

Time In: 1030

Time Out: 1130

Subjective: She is a 42-y.o.-year-old female who presents for outpatient physical **therapy** with a **chief complaint** of left shoulder and elbow chronic pain since February 2018. Left shoulder decompression on 5/24/19

EFFECTIVE DATE - 8/1/19

OF VISITS AUTHORIZED - 10 until 12/15/19

COPAY - \$15

PRECERT / PRIOR AUTH - YES

MEDICARE **THERAPY** CAP MET TO SOC DATE – N/A

PERSON SPOKE TO – CLEAR COVERAGE

REFERENCE # - M00945213

Height: 5'11"

Weight: 277 lbs

What is your profession? Disabled

Weight lifting requirements? Vacuuming, lifting her dog

Are you working currently? No

HPI: Admits to right hand dominance. Patient reports left shoulder, proximal and ACJ area, reported constant and aggravated by left sidelying, overhead reaching. Denies left UE pain or paresthesias. Denies constitutional signs, denies acute left shoulder symptoms. Pain is also reported at left distal tricipital area, dorsal forearm. Denies significant left shoulder crepitus.

History of previous injuries pertinent to your pain:

History of previous related surgeries: left shoulder decompression 5/24/19

Where is your pain located? Left shoulder dorsal aspect

Is your pain constant or intermittent? Constant

Distal paresthesias? No

Can you elicit distal symptoms with proximal movement? No

Alleviating factors? Rest, heat pads

Aggravating factors? Activity, overhead, lifting

Red Flags?

Patient denies diplopia, dysphagia, dysarthria, dizziness or drop attacks. Denies significant photophobia or sonophobia. Denies tinnitus. Denies upper lip or facial paresthesias, facial paralysis or difficulty to express emotions with facial expression. Denies feelings of spinal instability, new bowel or bladder incontinence. Denies saddle anesthesia, widespread limbs weakness or inability to evacuate bladder. Denies localized acute **findings**: throbbing, increased local temperature or effusion. Denies constitutional signs, fevers, chills or unexplained weight changes. Denies gnawing, lacerating pain in repose that disturbs sleep cycle.

Patient Precautions: **Anxiety**, RA, Chron's

Is your pain improving from initial onset? Some

Are you taking any medication related to your pain? No

Are you being physically abused? No

FOTO Data

FOTO Intake Completed: Yes

Intake FS Score: 61

Predicted FS Score: 69

Objective:

No significant deformity to superficial exam. No increased temperature, no swelling, redness or echymosis observed. Significant cervico-thoracic postural dysfunction: forward cervical spine, hypohyoid, prominent CTJ. Dermatomal exam C1-T1 to superficial pin/prick does not reveal sensory dysfunction. Deep Tendon Reflexes (bicipital, tricipital, brachioradialis) equal and symmetric, graded +2. Left shoulder ROM does not reveal significant restrictions or crepitus in all planes; pain behavior throughout testing without significant **objective findings**. Limited left scapulo-humeral rhythm during arm elevation. Left shoulder Muscle Testing does not reveal significant weakness. Grip strength Jamar 2: right 62# left 58# average.

No significant restriction observed during the exam of gleno-humeral, acromio-clavicular, sterno-clavicular or scapulo-thoracic joints. Positive left Speed, O'Brien, Hawkins-Kennedy, and Neer. Negative Empty Can and Negative Apley's. Generalized, unspecific tenderness triggered by left shoulder girdle and adjacent area palpation.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005
- **CT** 2005
- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- Irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure Laterality Date

- COLONOSCOPY N/A 6/24/2016
- Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/2/2017
- Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- COLONOSCOPY N/A 6/11/2018
- Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
- Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
- Procedure: ENDOSCOPY UPPER GI w/**BIOPSY**; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR

- EGD (GUTHRIE / NON GUTHRIE)
 - LAPAROSCOPIC CHOLECYSTECTOMY 2013 with liver **biopsy**
 - PR CLOSED RX TARSAL FX,EACH
 - PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY 12/10/2014 for obesity - Dr. Alley - RPH
 - PR REMOVAL GALLBLADDER
 - PR SHLDR ARTHROSCOP,PART ACROMIOPLAS Left 5/24/2019
- Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR
- TONSILLECTOMY 11/26/07

Current Outpatient Medications:

- ALPRAZolam (XANAX) 0.25 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg., Disp: 15 Tab, Rfl: 0
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap, Take 1,000 mg by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days, Disp: 10 mL, Rfl: 0
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc, 1 Each by Does not apply route EVERY 7 DAYS., Disp: 100 Each, Rfl: 0
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc, Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly, Disp: 100 Each, Rfl: 0
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab, Take 1 Tab by mouth DAILY., Disp: 84 Tab, Rfl: 0
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- loratadine (CLARITIN,ALAVERT) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution, Inject 1 mL beneath the skin EVERY SATURDAY., Disp: 12 mL, Rfl: 0
- Nitroglycerin 0.4 % Rectal Ointment, Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator., Disp: 1 Tube, Rfl: 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM, Disp: 12 Each, Rfl: 0
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease, Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 1
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR, Take 2 Caps by mouth DAILY., Disp: 180 Cap, Rfl: 1

Current Facility-Administered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Plan of Care

Plan of Care Start Date: 09/17/19

Plan of Care Expiration Date: 12/17/19

Rehabilitative **Prognosis:** Guarded

Assessment: Unspecific left shoulder pain likely related to sub-acromial compromise arising from significant, chronic postural dysfunction.

Patient presents with physical impairments resulting in pain production, ROM limitation, limited muscular recruitment, dysfunctional movement patterns, abnormal posture and overall decreased functional ability as noted by their FOTO score.

Clinical **findings** previously mentioned suggest patient may experience difficulty with the completion on ADL, work activities, recreational tasks and/or housework. Patient presents as a good candidate for skilled Physical **Therapy** services in the outpatient setting as evidenced by limited current level of functional performance, **ADLs**, recreational and work activities compared from previous functional levels.

Patient would benefit from skilled PT services to address these impairments. Patient functional progress and performance of therapeutic interventions will be monitored accordingly. Co-morbidities, life style choices and chronicity of **diagnosis** could negatively affect patient's overall progress.

Was Physical **Therapy** treatment performed at this visit?

Yes: Interventions: Home exercise program was demonstrated during today's intervention as indicated below. Patient voiced understanding of instructions and willingness to comply. Patient performed a substantial amount of exercise to become familiar with movement control and mechanics. All questions were answered.

Therapeutic Exercises (97110)

Patient Education/Home Exercise Program: yes

Number of Exercises?: 2

Total Minutes (all Therapeutic Exercise): 10

Exercise #1

Exercise Name: Thoracic extension in sitting and standing position during expiration

Reason for Exercise: Joint Mobility

Location/Body Area: Thoracic Spine

Sets/Reps: 2x5

Exercise #2

Exercise Name: Seated Row

Reason for Exercise: Strengthening

Location/Body Area: Thoracic Spine; Shoulder

Sets/Reps: 3x10

Resistance: red TB

Manual **Therapy** (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Left median and radial pumps/glides in supine.

Total Minutes (All Manual **Therapy**): 10

Plan for Next Visit: Physical **therapy** intervention will emphasize therapeutic exercise, neuromuscular re-education, manual **therapy**, modalities to control pain as deemed appropriate.

Evaluation Complexity **Assessment:** History Components: Moderate (1-2 personal factors and/or comorbidities)

Examination of Body Systems/Components: Moderate (Addressing a total of 3 or more elements)

Clinical Presentation: Stable - unchanging or predictable (Low)

Clinical Decision Making (complexity): Moderate

Treatment Number: 1

Total Time of Evaluation: 40

Total Number of Timed Code Treatment Minutes: 20

Author: Jose Traverso, DPT 9/17/2019 11:29

Formatting of this note might be different from the original.

The Guthrie Clinic
Initial Evaluation Plan of Care
Outpatient Physical **Therapy** Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL **THERAPY**
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 9/17/2019

Referring Physician: Michael F Gillan

Plan of Care Start Date: 09/17/19

Plan of Care Expiration Date: 12/17/19

Primary Diagnosis:

ICD-9-CM ICD-10-CM

1. Impingement syndrome of left shoulder 726.2 M75.42
2. Left elbow pain 719.42 M25.522

Rehabilitative **Prognosis:** Guarded

Goals:

Pain: Patient will report decrease in left shoulder pain to 2/10 or less when performing overhead activities, vacuuming, left sidelying.

Posture: Patient will demonstrate good awareness of proper sitting posture without cuing from therapist.
Able to lift her dog (<20 lbs) without significant left shoulder pain

Planned Intervention(s): PT Eval Moderate Complexity (97162);Neuro Re-Education (97112);Therapeutic Exercise (Timed) (97110);Manual **Therapy** (Timed) (97140);Ultrasound (Timed) (97035)

The above planned interventions may be used in Physical **Therapy** treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: 1-2 times a week

Duration of Treatment: 3 months

The Physical **Therapy** Plan of Care has been discussed with the patient. Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical **Therapy** treatment while under my care.

Gillan, Michael F, DO
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: Jose Traverso, DPT 9/17/2019 11:29

Electronically signed by Attia, Maximus, MD at 09/17/2019 2:01 PM EDT

Refill

Ripic, Shelli, CRNP

Encounter for contraceptive management, unspecified type

SAYRE
09/14/2019

885

Telephone Encounter - Slater, Ashley - 09/16/2019 8:11 AM EDT

PATIENT: Jennifer Lyn Brown

09/14/2019

Last Seen: 4/5/18
Upcoming Visit: None

Author: Ashley Slater 9/16/2019 08:11

Electronically signed by Slater, Ashley at 09/16/2019 8:12 AM EDT

Telephone Encounter - Ripic, Shelli, CRNP - 09/16/2019 9:55 AM EDT

Needs appointment.

Electronically signed by Ripic, Shelli, CRNP at 09/16/2019 9:55 AM EDT

Telephone Encounter - Simmons, Mary - 09/16/2019 11:24 AM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/16/2019

Patient informed birth control sent to pharmacy. Appt for annual set up for 10.3.19 with Shelli.

Author: Mary Simmons 9/16/2019 11:24

Electronically signed by Simmons, Mary at 09/16/2019 11:25 AM EDT

09/13/2019 Ocular Visit Galizia, Frank L, OD Myopia of both eyes (Primary Dx);
Allergic conjunctivitis of both eyes

SAYRE

09/13/2019

Progress Notes - Galizia, Frank L, OD - 09/13/2019 1:00 PM EDT

Formatting of this note might be different from the original.

Patient Name: Jennifer Lyn Brown
MRN: 340616
Date of Birth: 10/26/1976

Assessment:

ICD-9-CM ICD-10-CM

1. Myopia of both eyes 367.1 H52.13
2. Allergic conjunctivitis of both eyes 372.14 H10.13

Plan

Rx for replacement glasses, optional
Start Zaditor 2-3x/day /PRN
Monitor in one year

Author: Frank L Galizia, OD

Electronically signed by Galizia, Frank L, OD at 09/13/2019 1:27 PM EDT

09/11/2019 Refill Savino, Brigitte GAD (generalized **anxiety** disorder);
HTN (hypertension), benign

SAYRE

09/11/2019

Telephone Encounter - Savino, Brigitte - 09/11/2019 8:05 AM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/11/2019

Patient switching to express pharmacy

Clinic pharmacy called

Author: Brigitte Savino 9/11/2019 08:08

Electronically signed by Savino, Brigitte at 09/11/2019 8:12 AM EDT

Telephone Encounter - Gillan, Michael F, DO - 09/11/2019 8:14 AM EDT

Name: Jennifer Lyn Brown

DOB: 10/26/1976

MRN: 340616

Date of Service: 9/11/2019

Noted.

Sent to pharmacy.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 09/11/2019 8:14 AM EDT

09/04/2019

Gastro Nurse/clinical support

Crohn's disease of small intestine with other complication (HCC) (Primary Dx)

SAYRE

09/04/2019

Nursing Note - Williams, Kimberly, RN - 09/04/2019 9:30 AM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 9/4/2019

SUBJECTIVE:

Jennifer Lyn Brown is a 42-y.o. female patient of Dr. Georgetson. She comes accompanied by significant other to Department of Gastroenterology on 9/4/2019 for education regarding Stelara self injection. Her Stelara injections are ordered for Crohn's disease. Most recently Jennifer Lyn Brown has a history of:

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter

- Persistent mental disorders due to conditions classified elsewhere
 - Physiological ovarian cysts 10/7/2008
 - PLANTAR FIBROMATOSIS 9/9/2004
 - Premenopausal patient
 - Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
 - Sleep apnea
 - Thyroid nodule 6/3/2010
 - Wrist fracture

CURRENT MEDICATIONS:

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1,000 mg by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

ALLERGIES:

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

PHYSICAL EXAMINATION:

BP 120/76 (BP Location: Right arm, Patient Position: Sitting) | Pulse 80 | Temp 97 °F (36.1 °C) (Temporal) | Ht 5' 11" (1.803 m) | Wt 277 lb (125.6 kg) | BMI 38.63 kg/m²

Today's visit was spent reviewing Stelara **therapy** and Stelara injection technique. Jennifer Lyn Brown and significant other were instructed and received one subcutaneous injection to the left upper arm given by significant other, for a dose of 90 mg. She tolerated this well. Lot number for the Stelara was JASOSMC. Expiration 12/2021. Ms. Brown has received two prior

ASSESSMENT AND PLAN:

Jennifer Lyn Brown was instructed to contact our office with any questions or concerns. Her next injection will be Stelara 90 mg subcutaneous injection done at home, on 10/30/19. Her Stelara injection will be every 8 weeks.

AUTHOR:

Kimberly Williams, RN
SECTION OF GASTROENTEROLOGY
9/4/2019 10:15

Electronically signed by Williams, Kimberly, RN at 09/04/2019 10:45 AM EDT

Telephone

Savino, Brigitte

Medication Refill; Medication Refill

SAYRE

09/04/2019

Telephone Encounter - Savino, Brigitte - 09/04/2019 1:45 PM EDT

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 9/4/2019

Last seen 8-22-19

Last filled 8-15-19

Author: Brigitte Savino 9/4/2019 13:48

Electronically signed by Savino, Brigitte at 09/04/2019 1:56 PM EDT

Telephone Encounter - Gillan, Michael F, DO - 09/04/2019 2:03 PM EDT

Name: Jennifer Lyn Brown

DOB: 10/26/1976

MRN: 340616

Date of Service: 9/4/2019

These don't look due, please clarify.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 09/04/2019 2:03 PM EDT

Telephone Encounter - Savino, Brigitte - 09/04/2019 2:08 PM EDT

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 9/4/2019

Pharmacy is requesting refills

Author: Brigitte Savino 9/4/2019 14:08

Electronically signed by Savino, Brigitte at 09/04/2019 2:08 PM EDT

Telephone Encounter - Gillan, Michael F, DO - 09/04/2019 2:15 PM EDT

Formatting of this note might be different from the original.

Name: Jennifer Lyn Brown

DOB: 10/26/1976

MRN: 340616

Date of Service: 9/4/2019

Lab Results

Component Value Date

NA 137 08/26/2019

K 3.8 08/26/2019
CL 103 08/26/2019
CO2 23 08/26/2019
GLUCOSE 98 08/26/2019
BUN 12 08/26/2019
CREATININE 0.7 08/26/2019
CALCIUM 8.9 08/26/2019
EGFR >60 08/26/2019

EXHIBIT NO. B11F
PAGE: 33 OF 57

Done.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 09/04/2019 2:15 PM EDT

Telephone Encounter - Nolt, Raven, LPN - 09/05/2019 11:19 AM EDT

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/5/2019

Pharmacy is asking that a script for venlafaxine 37.5 mg be sent in for patient to take two due to the 75 mg tabs being on back order.

Author: Raven Nolt, LPN 9/5/2019 11:19

Electronically signed by Nolt, Raven, LPN at 09/05/2019 11:20 AM EDT

Telephone Encounter - Gillan, Michael F, DO - 09/05/2019 11:31 AM EDT

Name: Jennifer Lyn Brown
DOB: 10/26/1976
MRN: 340616
Date of Service: 9/4/2019

Done.

Michael F Gillan, DO

Electronically signed by Gillan, Michael F, DO at 09/05/2019 11:32 AM EDT

Addendum Note - Gillan, Michael F, DO - 09/05/2019 11:32 AM EDT

Addended by: GILLAN, MICHAEL F on: 9/5/2019 11:32 AM

Modules accepted: Orders

Electronically signed by Gillan, Michael F, DO at 09/05/2019 11:32 AM EDT
Refill Wood, Kelly A

SAYRE
09/03/2019

Telephone Encounter - Wood, Kelly A - 09/03/2019 2:16 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 9/3/2019

Requested Prescriptions

Pending Prescriptions Disp Refills
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution 12 mL 0
Sig: Inject 1 mL beneath the skin EVERY SATURDAY.
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc 12 Each 0

Sig: Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days

Last visit 7-10-19.

Next visit 10-16-19.

Labs 8-26-19.

Author: Kelly A Wood 9/3/2019 14:18

Electronically signed by Wood, Kelly A at 09/03/2019 2:19 PM EDT

Telephone Encounter - Jewell, Jan, RN - 09/03/2019 3:35 PM EDT

PATIENT: Jennifer Lyn Brown

MRN: 340616

DATE OF SERVICE: 9/3/2019

Patient called after Dr.Freeman reviewed e-guthrie message left message to call to make appointment to discuss issues with pain and current medications

Jan Jewell, RN 9/3/2019 15:35

Electronically signed by Jewell, Jan, RN at 09/03/2019 3:37 PM EDT

Refill

Hinds, Jennifer, LPN

SAYRE

09/03/2019

Telephone Encounter - Hinds, Jennifer, LPN - 09/03/2019 8:50 AM EDT

Last office visit 11/15/18. Has an appointment scheduled with Debra Moore on 10/29.
Jennifer Hinds, LPN

Electronically signed by Hinds, Jennifer, LPN at 09/03/2019 8:55 AM EDT

Telephone Encounter - Hinds, Jennifer, LPN - 09/04/2019 8:54 AM EDT

Formatting of this note might be different from the original.

Requested Prescriptions

Signed Prescriptions Disp Refills

- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution 10 mL 0

Sig: Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days

Authorizing Provider: GEORGETSON, MICHAEL

- foliC acid 1 MG Oral Tab 90 Tab 3

Sig: Take 1 Tab by mouth DAILY.

Authorizing Provider: GEORGETSON, MICHAEL

- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc 12 Each 0

Sig: Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM

Authorizing Provider: GEORGETSON, MICHAEL

Escribed to Pharmacy.

Jennifer Hinds, LPN

Electronically signed by Hinds, Jennifer, LPN at 09/04/2019 8:54 AM EDT

Telephone

Bashore, Shannon

SAYRE

08/30/2019

Telephone Encounter - Bashore, Shannon - 08/30/2019 10:09 AM EDT

Writer phoned patient to confirm appt for 9/3. Patient confirmed and Writer explained the location of the Dept at 3 green.

Electronically signed by Bashore, Shannon at 08/30/2019 10:09 AM EDT

Telephone

Bashore, Shannon

SAYRE

08/28/2019

Telephone Encounter - Bashore, Shannon - 08/28/2019 1:19 PM EDT

Writer called Patient to confirm her appt for tomorrow 8/29. Writer left a message on identified voicemail to please phone office back to confirm.

Electronically signed by Bashore, Shannon at 08/28/2019 1:21 PM EDT

08/26/2019 Telephone

Marshall, Pamela, LPN

SAYRE**08/26/2019**

Telephone Encounter - Marshall, Pamela, LPN - 08/26/2019 10:27 AM EDT

Prior authorization (new insurance) for Stelara was submitted thru navinet.

Electronically signed by Marshall, Pamela, LPN at 08/26/2019 10:29 AM EDT

Telephone Encounter - Marshall, Pamela, LPN - 08/26/2019 2:24 PM EDT

Prior authorization approved for Humira thru Excellus, authorization approved from 7/27/19 to 8/25/21 Case ID: 51024640.
 Patient must get her medication filled thru Accredo, faxed approval.

Order pended to Escribe to Accredo please sign

Electronically signed by Marshall, Pamela, LPN at 08/26/2019 2:27 PM EDT

08/22/2019 Hospital Encounter

Robert Packer Hospital
08/22/2019

Outpatient

Vitamin B 12 deficiency (Primary Dx);

HTN (hypertension), benign;
Severe obstructive sleep apnea;**Depression**, unspecified
depression type;

Impingement syndrome of left shoulder;

Left elbow pain

08/22/2019 Office Visit

Gillan, Michael F, DO

SAYRE**08/22/2019****Progress Notes** - Gillan, Michael F, DO - 08/22/2019 2:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 8/22/2019

CHIEF COMPLAINT:**Chief Complaint**

Patient presents with

- Medication Check

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI

1. Left elbow and shoulder pain:

- Has seen orthopedics for this.
- Had impingement syndrome, symptoms improving but pain is waking her up from sleep at night still.
- Requesting physical **therapy**.

2. **Anxiety:**

- Doing well on current medications.
- My APP had given her Xanax after discussion of risks, benefits, and alternatives.
- Patient requesting refill.
- I have reviewed this patients record on the Pennsylvania PDMP web site.

- No thoughts of hurting self or others.

- Using no diet or appropriate.

- Denies any additional issues or concerns with this.

3. OSA:

- Compliant with CPAP, using all night.

- Does not use it during naps, advised to do this as well.

4. Hypertension: The patient is taking hypertensive medications compliantly without side effects. Denies chest pain, dyspnea, edema, or TIA's.

Past Medical History:

Diagnosis Date

• Anal fissure 1/2013

• **Anxiety**

• Attention deficit

• Back ache 3/18/2014

• Calcaneal spur 6/30/2008

• Cherry angioma 8/9/2016

• Cholecystitis

• CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

• Crohn disease (HCC)

• **Depression** 1/20/2014

• Endocrine problem

• Epicondylitis elbow, medial 10/7/2008

• Fatty liver

• Fibromyalgia 8/20/2014

• Fractures

• Gastroparesis

irritable bowel syndrome

• GERD (gastroesophageal reflux disease) 10/7/2008

• HTN (hypertension), benign 10/7/2008

• Hypertension

• Morbidly obese (HCC)

• Multinodular goiter

• Nontoxic multinodular goiter 1/18/2011

• Obesity

• Persistent mental disorders due to conditions classified elsewhere

• Physiological ovarian cysts 10/7/2008

• PLANTAR FIBROMATOSIS 9/9/2004

• Premenopausal patient

• Rheumatoid arthritis(714.0) 12/12/2008

Sees Dr. Freeman in Elmira.

• Severe obstructive sleep apnea 6/10/2013

• Sleep apnea

• Thyroid nodule 6/3/2010

• Wrist fracture

Family History

Problem Relation Age of Onset

• Diabetes Mother

• Heart Mother

• Hypertension Mother

• Psychiatry Mother

Anxiety

• Arthritis Mother

• Heart Disease Mother

• Kidney Disease Mother

• Diabetes Father

• Hypertension Father

• Genetic Father

Marfan syndrome

• Heart Father

?Marfan's Syndrome

• Clotting Disorder Father

• Heart Disease Father

- Heart Paternal Uncle
- Aortic Dissection Paternal Uncle
- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt

ADHD

- Genetic Maternal Aunt

Marfan syndrome

- Psychiatry Other

ADHD

- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History
 • Not on file
 Social Needs
 • Financial resource strain: Not on file
 • Food insecurity:
 Worry: Not on file
 Inability: Not on file
 • Transportation needs:
 Medical: Not on file
 Non-medical: Not on file
 Tobacco Use
 • Smoking status: Never Smoker
 • Smokeless tobacco: Never Used
 Substance and Sexual Activity
 • Alcohol use: No
 Alcohol/week: 0.0 standard drinks
 • Drug use: No
 • Sexual activity: Yes
 Partners: Male
 Birth control/protection: Pill, Condom
 Comment: OCPs
 Lifestyle
 • Physical activity:
 Days per week: Not on file
 Minutes per session: Not on file
 • Stress: Not on file
 Relationships
 • Social connections:
 Talks on phone: Not on file
 Gets together: Not on file
 Attends religious service: Not on file
 Active member of club or organization: Not on file
 Attends meetings of clubs or organizations: Not on file
 Relationship status: Not on file
 • Intimate partner violence:
 Fear of current or ex partner: Not on file
 Emotionally abused: Not on file
 Physically abused: Not on file
 Forced sexual activity: Not on file
 Other Topics Concern
 • Not on file
 Social History Narrative
 August 2016: Works at Guthrie GI department. Lives with husband, has no children.

Over the last 2 weeks, have you been feeling down, depressed, anxious, or hopeless?: 0
 Over the past 2 weeks, have you felt little interest or pleasure in doing things?: 0
 Trouble falling or staying asleep, or sleeping too much?: 1
 Feeling tired or having little energy?: 1
 Poor appetite or overeating?: 0
 Feeling bad about yourself or that you are a failure or have let yourself or your family down?: 0
 Trouble concentrating on things, such as reading the newspaper or watching TV?: 0
 Moving or speaking so slowly that other people notice OR being fidgety and restless?: 0
 Thoughts that you would be better off dead or of hurting yourself in some way?: 0
 PHQ-9 TOTAL SCORE: 2

REVIEW OF SYSTEMS:

ROS

A comprehensive **review of systems** was conducted with the patient and is negative unless noted above.

Objective

PHYSICAL EXAM:

VITALS: BP 122/80 (BP Location: Left arm, Patient Position: Sitting) | Pulse 90 | Temp 99.4 °F (37.4 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 277 lb (125.6 kg) | SpO2 98% | BMI 38.63 kg/m² Body mass index is 38.63 kg/m².

Physical Exam

Constitutional: She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.
Nose: No nasal discharge.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Mallampati score of 3.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal.

Neck: Normal range of motion. Neck supple. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.

No CVA tenderness

Musculoskeletal:

Left shoulder: She exhibits tenderness. She exhibits normal range of motion, no bony tenderness, no swelling, no effusion, no spasm and normal strength.

Left elbow: She exhibits normal range of motion, no swelling, no effusion, no deformity and no laceration. Tenderness (diffuse) found. No radial head, no medial epicondyle, no lateral epicondyle and no olecranon process tenderness noted.

Cervical back: Normal.

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert. No cranial nerve deficit. Coordination normal.

Skin: Skin is warm. Capillary refill takes less than 2 seconds.

Psychiatric: She has a normal mood and affect. Judgment normal.

ASSESSMENT / IMPRESSION:

ICD-9-CM ICD-10-CM

1. Vitamin B 12 deficiency 266.2 E53.8

2. HTN (hypertension), benign 401.1 I10 lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab

3. Severe obstructive sleep apnea 327.23 G47.33

4. **Depression**, unspecified **depression** type 311 F32.9

5. Impingement syndrome of left shoulder 726.2 M75.42 REFER TO PHYSICAL **THERAPY** / REHAB

6. Left elbow pain 719.42 M25.522 XR ELBOW MIN 3 VIEWS LEFT (STANDARD)

REFER TO PHYSICAL **THERAPY** / REHAB

Plan

1. Vitamin B12 Deficiency:

- Obtains supplementation through GI.
- States she will contact them.

2. Hypertension:

- Well controlled.
- Continue on current **therapy**.
- Most recent renal function reviewed. Goal of BP is 140/90 or less.

3. OSA:

- Compliant with CPAP.
- Some disruptive sleep secondary to shoulder and elbow pain.
- She is going to follow up with her Orthoped and Rheumatologist.
- Overall symptoms improving.
- Agreeable to trying physical **therapy**.
- Agreeable to continuing with stretches, etc.
- Will obtain **x-ray** of elbow as well due to symptoms.

4. **Depression** and **anxiety**:

- Well controlled.
- Aware of risks of current medications, as well as benefits and alternatives.
- Rarely using Xanax, reviewed appropriate use.
- I have reviewed this patients record on the Pennsylvania PDMP web site.
- Consider counseling.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

X-ray of the left Elbow.

Start Physical **Therapy**.

Talk to GI about the B12.

I refilled your medications.

Call with any questions or concerns.

Michael F Gillan, DO

Author: Michael F Gillan, DO 8/22/2019 14:44

Electronically signed by Gillan, Michael F, DO at 08/22/2019 2:50 PM EDT

Nursing Note - Myers, Thomas, LPN - 08/22/2019 2:00 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 8/22/2019

Chief Complaint

Patient presents with

- Medication Check

Author: Thomas Myers, LPN 8/22/2019 13:57

Electronically signed by Myers, Thomas, LPN at 08/22/2019 2:47 PM EDT

07/16/2019 Telephone Shaw, Beth, RN Other (request for disability)

SAYRE

07/16/2019

Telephone Encounter - Shaw, Beth, RN - 07/16/2019 2:25 PM EDT

Received request from New York State office of Temporary and Disability Assistance for form completion by Dr.M.Georgetson.

Placed on Dr.Georgetson's desk for review and signature. Once completed, forms to be faxed to Medical Records to complete request for copy of any studies.

Electronically signed by Shaw, Beth, RN at 07/16/2019 2:29 PM EDT

Telephone Encounter - Shaw, Beth, RN - 07/24/2019 3:07 PM EDT

After completed forms filled out and signed by Dr. Georgetson, forms faxed to the Medical Records Department, to have all other requested records faxed to NYS office of Temporary and Disability Assistance Division of Disability Determination at 1-866-323-8335.

07/10/2019 Electronically signed by Shaw, Beth, RN at 07/24/2019 3:12 PM EDT
Office Visit Freeman, James, MD Enteropathic arthritis (Primary Dx);
Family history of Marfan syndrome

SAYRE

07/10/2019

Progress Notes - Freeman, James, MD - 07/10/2019 3:40 PM EDT

Formatting of this note might be different from the original.

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 7/10/2019

CHIEF COMPLAINT:

• Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI Jennifer Lyn Brown is a 42-y.o. female is here for her follow up visit.

HPI

Jennifer Lyn Brown is a 42-y.o. Female With PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humira after she developed skin rash and allergy to remicade. She developed drug induced lupus on Humira, and then changed to Ustekinumab by GI, methotrexate 25mg SC Q weekly. She had been doing well until she underwent shoulder surgery a few months ago. The recovery has been slow. In addition, she has been under a lot of stress due to work and family issues. She finally stopped working. In any case, she has had more aches and pains in her hips and knees without swelling. Morning stiffness under 20 minutes. She isn't sure if the joint pains are related to more active arthritis vs stress vs both. She is having no trouble tolerating her medications in the way of infections, stomach upset, or lab abnormalities. Recent ESR was normal. Her Crohn's symptoms have been well controlled.

Past Medical History:

Diagnosis Date

- Anal fissure 1/2013
- **Anxiety**
- Attention deficit
- Back ache 3/18/2014
- Calcaneal spur 6/30/2008
- Cherry angioma 8/9/2016
- Cholecystitis
- CHRONIC SINUSITIS NOS 5/23/2005

CT 2005

- Crohn disease (HCC)
- **Depression** 1/20/2014
- Endocrine problem
- Epicondylitis elbow, medial 10/7/2008
- Fatty liver
- Fibromyalgia 8/20/2014
- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem Relation Age of Onset

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother

Anxiety

- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father

- Hypertension Father
- Genetic Father
- Marfan syndrome
- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle
- Aortic Dissection, Marfan's Syndrome
- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt
- ADHD
- Genetic Maternal Aunt
- Marfan syndrome
- Psychiatry Other
- ADHD
- **Cancer** Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication Sig

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased **anxiety**). Max Daily Amount: 0.75 mg.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- HYDROcodone-acetaminophen (NORCO) 5-325 MG Oral Tab Take 1 Tab by mouth EVERY FOUR HOURS AS NEEDED (Pain, continued treatment). Max Daily Amount: 6 Tabs.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 1 mL beneath the skin EVERY SATURDAY.
- Nitroglycerin 0.4 % Rectal Ointment Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen Reactions

- Bee Stings [Bee Sting] Swelling
- Oxycodone Hives
- Remicade [Infliximab] Rash
- Tape: Silk Or Adhesive Rash

Social History

- Marital status: Separated

Spouse name: Not on file

- Number of children: Not on file

- Years of education: Not on file

- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file

- Food insecurity:

Worry: Not on file

Inability: Not on file

- Transportation needs:

Medical: Not on file

Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker

- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No

Alcohol/week: 0.0 standard drinks

- Drug use: No

- Sexual activity: Yes

Partners: Male

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

- Physical activity:

Days per week: Not on file

Minutes per session: Not on file

- Stress: Not on file

Relationships

- Social connections:

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

- Intimate partner violence:

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:**Review of Systems**

Constitutional: Negative.

HEENT: Negative.

Eyes: Negative.

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: Positive for abdominal pain.

She has intermittent RLQ discomfort attributed to ovarian cyst

Musculoskeletal: Positive for joint pain.

Skin: Negative.

Neurological: Negative.

Endo/Heme/Allergies: Negative.

Objective

PHYSICAL EXAM:

VITALS: BP 110/70 | Ht 5' 11" (1.803 m) | Wt 279 lb (126.6 kg) | BMI 38.91 kg/m² Body mass index is 38.91 kg/m².

Physical Exam

Constitutional: She appears well-developed.

Eyes: Conjunctivae are normal.

Neck: Normal range of motion. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

Pulmonary/Chest: Breath sounds normal.

Abdominal: Soft.

Musculoskeletal: Normal range of motion. She exhibits no edema, tenderness or deformity.

ASSESSMENT / IMPRESSION:

Enteropathic arthritis

Plan

Continue current **therapy**

RV 3 months

Author: James Freeman, MD 7/17/2019 17:03

Electronically signed by Freeman, James, MD at 07/17/2019 5:06 PM EDT

07/08/2019

Telephone

Bell, Janine, RN

Other (Disability)

SAYRE**07/08/2019**

Telephone Encounter - Bell, Janine, RN - 07/08/2019 3:13 PM EDT

Received request from New York State office of Temporary and Disability Assistance for form completion by Dr T McDonald.

Contacted K. Richardson, disability analyst. Discussed Dr McDonald has not seen Ms Brown as a patient in our office. He has performed colonoscopies for her. Pt sees Dr Georgetson as her GI provider. Ms Richardson requests a note be faxed with this information to 866-323-8335. New disability forms will then be sent to Dr Georgetson.

Disability form faxed back as requested, stating Dr Georgetson is her GI provider. Received confirmation of receipt. Janine Bell, RN

07/05/2019

Electronically signed by Bell, Janine, RN at 07/08/2019 3:25 PM EDT

Office Visit

Watson, Brittany, PA

Orthopedic aftercare (Primary Dx)

SAYRE**07/05/2019****Progress Notes** - Watson, Brittany, PA - 07/05/2019 11:15 AM EDT

Formatting of this note might be different from the original.

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 7/5/2019

Chief Complaint

Patient presents with

- Follow Up

RS SAD DCE 5/24/19, ROM WNL, Some pain other than that no complaints at this time.

HPI: Jennifer Lyn Brown is a 42-y.o. female who is here for follow up 6 weeks status post left shoulder subacromial decompression, distal clavicle excision. Patient states that she is doing very well. She states she has been doing her exercises as instructed. She has very minimal pain. Overall, pleased with her **results**. Denies tingling, burning, numbness distally.

Physical Exam:

Shoulder:

Forward flexion: 170

External rotation: 45

Internal rotation: L2

Strength: 5/5

Neurological: Sensation intact distally.

Impression:

ICD-9-CM ICD-10-CM

1. Orthopedic aftercare V54.9 Z47.89

Plan:

Her questions and concerns were addressed and answered to her satisfaction. She is doing well. Motion and strength are nearly full. She may resume activities as tolerated. Continue exercise program. Follow up as needed. She may contact our office with any questions or concerns.

Author: Brittany Watson, PA 7/5/2019 13:01

Electronically signed by Watson, Brittany, PA at 07/05/2019 1:02 PM EDT

Nursing Note - Albers, Nichole, LPN - 07/05/2019 11:15 AM EDT

NAME: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 7/5/2019

CONSTITUTIONAL: negative.

HEENT: negative.

EYES: negative

RESPIRATORY: negative.

CARDIOVASCULAR: negative.

GASTROINTESTINAL: negative.

GENITOURINARY: negative.

INTEGUMENT/BREAST: negative.

HEMATOLOGIC/LYMPHATIC: negative.

MUSCULOSKELETAL: negative except RS SAD DCE 5/24/19, ROM WNL, Some pain other than that no complaints at this time.

RS SAD DCE 5/24/19, ROM WNL, Some pain other than that no complaints at this time.

NEUROLOGICAL: negative.

BEHAVIORAL/PSYCH: negative.

ENDOCRINE: negative.

ALLERGIC/IMMUNOLOGIC: Negative.

Body mass index is 39.89 kg/m². Patient aware

AUTHOR: Nichole Albers, LPN 7/5/2019 11:30

Electronically signed by Albers, Nichole, LPN at 07/05/2019 11:30 AM EDT

06/27/2019 Telephone

Shaw, Beth, RN

Discuss Patient Care (need for TB Gold)

SAYRE**06/27/2019**

Telephone Encounter - Shaw, Beth, RN - 06/27/2019 1:12 PM EDT

Message left for patient on Home phone, mobile phone and e-guthrie.

"If at all possible, please have your TB Gold drawn today before 230 pm, if you are still under the Guthrie Highmark insurance for the month of June. TB Gold cannot be drawn after 230 PM Thursdays and not at all on Fridays, since this is a send out lab. (Monday is July 1). You also have 3 month lab orders in your chart per Dr.Georgetson, but they are not due until 9/15/19".

Electronically signed by Shaw, Beth, RN at 06/27/2019 1:13 PM EDT

06/26/2019 Hospital Encounter

Robert Packer Hospital**06/26/2019**

Outpatient

06/26/2019 Gastro Nurse/clinical support

Crohn's disease of small intestine with other complication (HCC) (Primary Dx)

SAYRE**06/26/2019**

Nursing Note - Williams, Kimberly, RN - 06/26/2019 3:30 PM EDT

Patient arrives with significant other for every 8 week injection of Stelara. Patient identified by verbalizing name and date of birth. Stelara 90 mg given SQ to right upper arm. Tolerates well with NAR. Band-aid applied. Escorted to desk to schedule 8

06/26/2019 Telephone

Williams, Kimberly, RN

Orders (tab and procedure)

SAYRE

06/26/2019

Telephone Encounter - Williams, Kimberly, RN - 06/26/2019 4:06 PM EDT

Orders pended for yearly quantiferon TB gold. Hx Crohn's on Stelara. Last done 3/18. Please sign. Thanks.

Electronically signed by Williams, Kimberly, RN at 06/26/2019 4:09 PM EDT

from 06/26/2019 to 10/24/2019

PROCED

Procedures

Non-identified Provider

Date	Procedure/Encounter Type [Code]
08/28/2019	QUANTIFERON(R) - TB GOLD [86480]
08/26/2019	VAP Pnl SerPI [53575-7]
08/26/2019	CRP SerPI-mCnc [1988-5]
08/26/2019	Comp Metab 2000 Pnl SerPI [24323-8]
08/26/2019	CBC WITH DIFFERENTIAL [85025]
08/26/2019	ESR Bld Qn 15M [43402-7]
08/25/2019	HC ELBOW, MIN OF 3 VIEWS [73080]
06/27/2019	HC SCR MAMMO BI INCL CAD [77067]

Narrative Text

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
QUANTIFERON(R) - TB GOLD	Routine	08/28/2019 2:30 PM EDT	History of immunosuppressive therapy	Results for this procedure are in the results section.
COMPREHENSIVE METABOLIC PANEL	Routine	08/26/2019 9:50 AM EDT	Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section.
C-REACTIVE PROTEIN	Routine	08/26/2019 9:50 AM EDT	Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section.
LIPID PROFILE	Routine	08/26/2019 9:50 AM EDT	Screening for hyperlipidemia	Results for this procedure are in the results section.
SEDIMENTATION RATE	Routine	08/26/2019 9:27 AM EDT	Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section.
CBC WITH DIFFERENTIAL	Routine	08/26/2019 9:27 AM EDT	Crohn's disease with other complication, unspecified gastrointestinal tract location (HCC)	Results for this procedure are in the results section.
XR ELBOW MIN 3 VIEWS LEFT (STANDARD)	Routine	08/25/2019 10:54 AM EDT	Left elbow pain	Results for this procedure are in the results section.

from 06/26/2019 to 10/24/2019

LABS

Laboratory Results

Narrative Text				
• CBC WITH DIFFERENTIAL (08/26/2019 9:27 AM EDT)				
Component	Value	Ref Range	Performed At	Pathologist Signature
WBC Count	8.27	3.98 - 10.04 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
RBC Count	4.49	3.93 - 5.22 M/UL	GUTHRIE MEDICAL GROUP LABORATORY	
Hemoglobin	13.1	11.2 - 15.7 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Hematocrit	39.9	34.1 - 44.9 %	GUTHRIE MEDICAL GROUP LABORATORY	
MCV	88.9	79.4 - 94.8 FL	GUTHRIE MEDICAL GROUP LABORATORY	
MCH	29.2	25.6 - 32.2 PG	GUTHRIE MEDICAL GROUP LABORATORY	
MCHC	32.8	32.2 - 35.5 g/dL	GUTHRIE MEDICAL GROUP LABORATORY	
Platelet Count	290	182 - 369 K/uL	GUTHRIE MEDICAL GROUP LABORATORY	
MPV	9.5	9.4 - 12.3 FL	GUTHRIE MEDICAL GROUP LABORATORY	
RDW	13.2	11.7 - 14.4 %	GUTHRIE MEDICAL GROUP LABORATORY	
Neutrophil %	55.7	34.0 - 71.1 %	GUTHRIE MEDICAL GROUP LABORATORY	
Lymphocyte %	30.8	19.3 - 51.7 %	GUTHRIE MEDICAL GROUP LABORATORY	
Monocyte %	10.9	4.7 - 12.5 %	GUTHRIE MEDICAL GROUP LABORATORY	
Eosinophil %	1.8	0.7 - 5.8 %	GUTHRIE MEDICAL GROUP LABORATORY	
Basophil %	0.7	0.1 - 1.2 %	GUTHRIE MEDICAL GROUP LABORATORY	
nRBC %	0.0	0.0 - 0.2 %	GUTHRIE MEDICAL GROUP	

Neutrophil #	4.56	1.15 - 1.15 K/uL	LABORATORY GUTHRIE MEDICAL GROUP
Lymphocyte #	2.55	1.18 - 3.74 K/UL	LABORATORY GUTHRIE MEDICAL GROUP
Monocyte #	0.90 (H)	0.24 - 0.86 K/UL	LABORATORY GUTHRIE MEDICAL GROUP
Eosinophil #	0.15	0.04 - 0.36 K/UL	LABORATORY GUTHRIE MEDICAL GROUP
Basophil #	0.06	0.01 - 0.08 K/UL	LABORATORY GUTHRIE MEDICAL GROUP
Immature Gran %	0.1	0.0 - 0.4 %	LABORATORY GUTHRIE MEDICAL GROUP
Immature Gran #	0.01	0.00 - 0.03 K/uL	LABORATORY GUTHRIE MEDICAL GROUP
NRBC #	0.00	0.00 - 0.12 K/uL	LABORATORY GUTHRIE MEDICAL GROUP

Specimen

Blood - Blood specimen (specimen)

Performing Organization**Address****City/State/Zipcode****Phone Number**GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

• **QUANTIFERON(R) - TB GOLD (08/28/2019 2:30 PM EDT)**

Component	Value	Ref Range	Performed At	Pathologist Signature
Quantiferon TB Gold	NEGATIVE	NEGATIVE	QUEST DIAGNOSTICS	

Comment:

M.TUBERCULOSIS INFECTION NOT LIKELY
The Nil tube value reflects the background interferon gamma response of the patient's blood sample. This value has been subtracted from the patient's displayed TB and Mitogen **results.**

Lower than expected **results** with the Miltogen tube prevent false-negative Quantiferon readings by detecting a patient with a potential immune suppressive condition and/or suboptimal pre-analytical specimen handling.

The TB1 Antigen tube is coated with the M. tuberculosis-specific antigens designed to elicit responses from TB antigen primed CD4+ helper T-lymphocytes.

The TB2 Antigen tube is coated with the M. tuberculosis-specific antigens designed to elicit responses from TB antigen primed CD4+ helper and CD8+ cytotoxic T-lymphocytes.

For additional information, please refer to:

In healthy persons who have a low likelihood both of M.tuberculosis infection and of progression to active tuberculosis if infected, a single positive QFT **result** should not be taken as reliable evidence of M.tuberculosis infection. Repeat testing, with either the initial test or a different test, may be considered on a case-by-case basis.

The CDC advises that caution is warranted when using the assay in children aged <5 years (MMWR2010;59(RR-05):1-25).

QUANTIFERON NIL	0.02	IU/ML	QUEST DIAGNOSTICS
QUANTIFERON MITOGEN-NIL	>10.00	IU/ML	QUEST DIAGNOSTICS
TB1-NIL	0.00	IU/ML	QUEST DIAGNOSTICS
TB2-NIL	0.00	IU/ML	QUEST DIAGNOSTICS

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/Zipcode	Phone Number
QUEST DIAGNOSTICS	875 GREENTREE RD, 4 PARKWAY CENTER	PITTSBURGH, PA 15220	607-936-0146

• C-REACTIVE PROTEIN (08/26/2019 9:50 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
C-Reactive Protein	0.60	<1.00 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/Zipcode	Phone Number
GUTHRIE MEDICAL GROUP LABORATORY	1 GUTHRIE SQUARE	SAYRE, PA 18840	570-887-4719

• LIPID PROFILE (08/26/2019 9:50 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Cholesterol	167	<200 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
HDL Cholesterol	52	>50 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Triglycerides	136	<150 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
LDL Cholesterol	88	<100 MG/DL	GUTHRIE MEDICAL GROUP LABORATORY	
Cholesterol / HDL Ratio	3.2	RATIO	GUTHRIE MEDICAL GROUP LABORATORY	
LDL / HDL Ratio	1.7		GUTHRIE MEDICAL GROUP LABORATORY	
Non-HDL	115	0 - 130 MG/DL	GUTHRIE MEDICAL	

Specimen

GROUP
LABORATORYEXHIBIT NO. B11F
PAGE: 50 OF 57

Blood - Blood specimen (specimen)

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP
LABORATORY

1 GUTHRIE SQUARE

SAYRE, PA 18840

570-887-4719

• COMPREHENSIVE METABOLIC PANEL (08/26/2019 9:50 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Sodium	137	134 - 145 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Potassium	3.8	3.5 - 5.1 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Chloride	103	98 - 107 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
CO2	23	22 - 30 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY	
Calcium	8.9	8.3 - 10.1 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Albumin	4.1	3.5 - 5.0 g/dl	GUTHRIE MEDICAL GROUP LABORATORY	
BUN	12	7 - 17 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Creatinine	0.7	0.7 - 1.2 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Glucose	98	70 - 99 mg/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Total Protein	7.2	6.3 - 8.2 g/dl	GUTHRIE MEDICAL GROUP LABORATORY	
Total Bilirubin	0.2	0.0 - 1.1 MG/DL	GUTHRIE MEDICAL GROUP LABORATORY	
AST	24	15 - 46 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
ALT	14	9 - 52 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
Alkaline Phosphatase	48	40 - 150 U/L	GUTHRIE MEDICAL GROUP LABORATORY	
eGFR	>60	See Interpretation Below ml/min/1.73ml Sq	GUTHRIE MEDICAL GROUP LABORATORY	
Comment:				

Estimated GFR Interpretation:
 Above 60ml/min/1.73m2 = Normal
 Renal Function
 30-59 ml/min/1.73m2 = Stage 3 Chronic
 Kidney Disease
 15-29 ml/min/1.73m2 = Stage 4 Chronic
 Kidney Disease
 Less than 15 ml/min/1.73m2 = Stage 5
 Chronic Kidney Disease

The GFR value is calculated using the

BUN/Creatinine Ratio	17	6 - 22 RATIO	GUTHRIE MEDICAL GROUP LABORATORY
Anion Gap	11	3 - 11 mmol/L	GUTHRIE MEDICAL GROUP LABORATORY
A/G Ratio	1.3	0.8 - 2.0 ratio	GUTHRIE MEDICAL GROUP LABORATORY

Specimen

Blood - Blood specimen (specimen)

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
 LABORATORY

SAYRE, PA 18840

570-887-4719

• SEDIMENTATION RATE (08/26/2019 9:27 AM EDT)

Component

Value

Ref Range

Performed At

Pathologist Signature

ESR 8 0 - 20 MM/HR

GUTHRIE MEDICAL GROUP
 LABORATORY

Comment:

Methodology was changed 6/26/19.
 Please note updated reference range.

Specimen

Blood - Blood specimen (specimen)

Performing Organization

Address

City/State/Zipcode

Phone Number

GUTHRIE MEDICAL GROUP 1 GUTHRIE SQUARE
 LABORATORY

SAYRE, PA 18840

570-887-4719

• XR ELBOW MIN 3 VIEWS LEFT (STANDARD) (08/25/2019 10:54 AM EDT)

Specimen

Impressions

Performed At

No fracture. No significant joint effusion.

Signed by Ananth Ravi on 8/25/2019 10:54 AM

Narrative

Performed At

Procedure(s): XR ELBOW MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/22/2019 2:54 PM

Provided clinical information: 42 years, Female, "elbow pain"

Procedure and materials: Standard protocol.

Comparison studies: March, 2016.

...

Procedure Note

Interface, Rad **Results** - 08/25/2019 10:56 AM EDT

Procedure(s): XR ELBOW MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/22/2019 2:54 PM

Provided clinical information: 42 years, Female, "elbow pain"

Procedure and materials: Standard protocol.

Comparison studies: March, 2016.

...

No fracture. No significant joint effusion.

Signed by Ananth Ravi on 8/25/2019 10:54 AM

- MAMMO SCREENING TOMOSYNTHESIS BILATERAL (06/27/2019 10:16 AM EDT)

Specimen**Impressions****Performed At**

Negative. No mammographic evidence of malignancy.

Recommend annual screening mammogram.

BI-RADS **Assessment**: Category 1: Negative

Management Recommendation: Routine annual screening mammography.

Signed by Elizabeth Werner, MD on 6/27/2019 10:16 AM

Narrative**Performed At**

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Date of service: 6/26/2019 4:39 PM

Provided clinical information: 42-year-old asymptomatic female for screening mammogram

Procedure and materials: Bilateral 2-D digital mammography and 3-D digital breast tomosynthesis in CC and MLO projections were obtained. 2-D images were analyzed by a CAD system.

Comparison studies: 1/25/18, 6/5/17, 11/21/16.

Most recent clinical breast exam: A year ago.

Observations:

Breast composition: b. There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: None.

Other pertinent **findings**: None.

Procedure Note

Interface, Rad **Results** - 06/27/2019 10:19 AM EDT

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Date of service: 6/26/2019 4:39 PM

Provided clinical information: 42-year-old asymptomatic female for screening mammogram

Procedure and materials: Bilateral 2-D digital mammography and 3-D digital breast tomosynthesis in CC and MLO projections were obtained.

Most recent clinical breast exam: A year ago.

Observations:

Breast composition: b. There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: None.

Other pertinent **findings**: None.

IMPRESSION

Negative. No mammographic evidence of malignancy.

Recommend annual screening mammogram.

BI-RADS **Assessment**: Category 1: Negative

Management Recommendation: Routine annual screening mammography.

Signed by Elizabeth Werner, MD on 6/27/2019 10:16 AM

from 06/26/2019 to 10/24/2019

VITALS

Vital Signs

<u>Type</u>	<u>Date</u>	<u>Interpretation</u>	<u>Value</u>	<u>Ref Range</u>
BP dias	10/03/2019		90 mm[Hg]	
BP sys	10/03/2019		140 mm[Hg]	
Bdy height	10/03/2019		180.3 cm	
Body temperature	09/04/2019		36.11 Cel	
Heart rate	09/04/2019		80 /min	
Resp rate	08/22/2019		18 /min	
SaO2 % BldA PulseOx	08/22/2019		98 %	
Weight	10/03/2019		127.642 kg	

Narrative Text

Vital Sign	Reading	Time Taken	Comments
Blood Pressure	140 / 90	10/03/2019 10:59 AM EDT	910

Pulse	80	09/04/2019 9:26 AM EDT
Temperature	36.1-36.19°C	09/04/2019 9:27 AM EDT
Respiratory Rate	18	08/22/2019 1:57 PM EDT
Oxygen Saturation	98%	08/22/2019 1:57 PM EDT
Inhaled Oxygen Concentration	-	-
Weight	127.6 kg (281 lb 6.4 oz)	10/03/2019 10:59 AM EDT
Height	180.3 cm (5' 11")	10/03/2019 10:59 AM EDT
Body Mass Index	39.25	10/03/2019 10:59 AM EDT

MEDS

Medication Information

Non-identified Provider						
Date	Product	Indication	Status	Dose	Frequency	Quantity
10/05/2019	0703-3671-01		Active	12.5 mg	Unknown	12
10/02/2019	0591-0796-01		Active	1500 mg	Every .5d	120
10/02/2019	0378-2625-01		Active	25 mg	Unknown	90
09/16/2019	68180-857-11	Diagnosis interpretation	Active	1 {tbl}	Unknown	84
09/11/2019	0093-7386-56	Diagnosis interpretation	Active	150 mg	Unknown	90
09/11/2019	0093-7384-56	Diagnosis interpretation	Active	75 mg	Unknown	180
09/11/2019	0378-6689-10		Active	40 mg	Unknown	90
09/11/2019	0378-2075-10	Diagnosis interpretation	Active	20 mg	Unknown	90
09/04/2019	183860		Inactive	90 mg	Unknown	
09/04/2019	147869		Active	1 mL	Unknown	12
09/04/2019	10370-102-03	Diagnosis interpretation	Active	300 mg	Unknown	90
09/03/2019	0517-0032-25		Active	1000 ug	Unknown	10
09/03/2019	10135-182-01		Active	1 mg	Unknown	90
09/03/2019	147869		Active	1 mL	Unknown	12
08/26/2019	183860	Problem	Active	90 mg	Unknown	1
08/22/2019	0228-2027-10		Active	0.25 mg	Unknown	15
06/26/2019	183860	Diagnosis interpretation	Inactive	90 mg	Unknown	
03/13/2019	94046-00168		Active	1 {each}	Unknown	100
11/21/2018	11917-01257	Diagnosis interpretation	Active	2 {spray}	Unknown	
09/20/2018	11917-09905		Active	1 {capsule}	Unknown	90
08/17/2018	0517-0032-25		Inactive	1000 ug	Unknown	12
06/21/2018	182038	Diagnosis interpretation	Active	.3 mg	Unknown	1
05/23/2018	45749-01781		Active	1 {capsule}	Unknown	60
03/13/2018	0054-3270-99	Diagnosis interpretation	Active	2 {spray}	Unknown	1
03/13/2018	0781-5077-01	Diagnosis interpretation	Active	10 mg	Unknown	30
09/05/2017	11917-05038		Active	600 mg	Every .5d	60
02/23/2017	0378-0751-01	Diagnosis interpretation	Active	10 mg	Unknown	42
08/17/2016	0378-7734-93		Active	8 mg	Unknown	30

Narrative Text						
Medication	Sig	Dispensed	Refills	Start Date	End Date	Status
ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.	30 Tab	1	08/17/2016		Active
cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.	42 Tab	0	02/23/2017		Active

Case 6:21-cv-06189-LGF Document 18 Filed 08/27/23 Page 916 of 1112					
Indications: Trapezius muscle spasms calcium carbonate (CALTRATE) 600 MG Oral Tab fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Take 1 Tab by mouth TWICE DAILY. Spray 2 Sprays in nose DAILY.	60 Tab 1 Bottle	5 0	09/05/2017 03/13/2018	Active Active
Indications: Nasal congestion					
loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.	30 Tab	0	03/13/2018	Active
Indications: Nasal congestion					
Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn	60 Cap	3	05/23/2018	Active
EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).	1 Each	3	06/21/2018	Active
Indications: Bee sting reaction, accidental or unintentional, initial encounter					
Cholecalciferol (VITAMIN D3) 1000 units Oral Cap	Take 1 Cap by mouth DAILY.	90 Cap	3	09/20/2018	Active
Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.	100 Each	0	03/13/2019	Active
ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.	15 Tab	0	08/22/2019	Active
Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease	1 Syringe	5	08/26/2019	Active
Indications: Crohn's Disease					
cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days	10 mL	0	09/03/2019	11/06/2019 Active
foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.	90 Tab	3	09/03/2019	Active
Syringe/Needle, Disp, 25G X 1- 1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM	12 Each	0	09/03/2019	Active
Syringe/Needle, Disp, 25G X 1- 1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days	12 Each	0	09/04/2019	Active
buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.	90 Tab	1	09/04/2019	Active
Indications: Depression , unspecified depression type					
venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1	09/11/2019	Active
Indications: GAD (generalized anxiety disorder)					
venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR	Take 2 Caps by mouth DAILY.	180 Cap	1	09/11/2019	Active
Indications: GAD (generalized anxiety disorder)					
pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.	90 Tab	1	09/11/2019	Active

Indications: HTN (hypertension), benign levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab						
	Take 1 Tab by mouth DAILY.	84 Tab	0	09/11/2019		Active
Indications: Encounter for contraceptive management, unspecified type methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution						
	Inject 0.5 mL beneath the skin EVERY SATURDAY.	12 mL	0	10/05/2019		Active
sulfasalazine (AZULFIDINE) 500 MG Oral Tab						
	Take 3 Tabs by mouth TWICE DAILY.	120 Tab	2	10/02/2019		Active
amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab						
	Take 1 Tab by mouth EVERY BEDTIME.	90 Tab	0	10/02/2019		Active
cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution						
	Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses.	12 mL	0	08/17/2018	07/14/2019	Expired
Hospital, Clinic, or Other Facility Administered Medication	Ordered Dose	Route	Frequency	Start Date	End Date	Status
saline (OCEAN) nasal spray 0.65 %						
	2 Spray	NA	Q2 HRS PRN	11/21/2018		Active
Indications: Acute URI						
	Ustekinumab 90 MG/ML SOSY	90 mg	SC	X1	06/26/2019	06/26/2019 Ended
Indications: Crohn's disease of small intestine with other complication (HCC)						
	Ustekinumab 90 MG/ML SOSY (Ordered as: STELARA)	90 mg	SC	NOW	09/04/2019	09/04/2019 Ended

CARE PLAN

Plan of Care

Narrative Text

Upcoming Encounters					
Date	Type	Specialty	Care Team	Description	
10/29/2019	Office Visit		Moore, Debra, NP		
			1 Guthrie Square		
			Sayre, PA 18840		
			570-887-2852		
			570-887-2345 (Fax)		
11/15/2019	Office Visit		Gillan, Michael F, DO		
			1 GUTHRIE SQUARE		
			SAYRE, PA 18840		
			570-887-2239		
			570-887-3285 (Fax)		
12/11/2019	Office Visit				
09/15/2020	Ocular Visit		Galizia, Frank L, OD		
			1 GUTHRIE SQUARE		

570-887-3234

570-887-3236 (Fax)

Health Maintenance	Due Date	Last Done	Comments
INFLUENZA VACCINE (#1)	09/01/2019	10/03/2018, 10/11/2017, 09/22/2016, Additional history exists	
MAMMOGRAM (SCREENING)	06/26/2020	06/26/2019, 06/25/2018, 06/05/2017, Additional history exists	
PNEUMOCOCCAL 0-64 YRS (2 of 3 - PCV13)	08/07/2020	07/08/2016	Postponed from 07/08/2017 (Other)
DEPRESSION SCREENING	08/22/2020	08/22/2019, 08/22/2019	
DIABETES SCREENING	08/26/2020	08/26/2019, 06/06/2019, 05/06/2019, Additional history exists	
LIPID DISORDER SCREENING	08/26/2020	08/26/2019, 03/12/2018, 01/12/2016, Additional history exists	
PAP SMEAR	04/05/2021	04/05/2018, 06/02/2015, 02/11/2014, Additional history exists	
COLONOSCOPY SCREENING	06/11/2021	06/11/2018, 06/11/2018, 06/02/2017, Additional history exists	
HIV SCREENING	Completed	03/12/2018	
HPV IMMUNIZATION SERIES	Aged Out		No longer eligible based on patient's age to complete this topic
MENINGOCOCCAL VACCINE IMM	Aged Out		No longer eligible based on patient's age to complete this topic

PROV LIST

Healthcare Providers

The Guthrie Clinic (05/01/2015 - No Date Available)

Provider Name	Address	Telecom	MRN
Michael F Gillan, DO	1 GUTHRIE SQUARE SAYRE, PA 18840	tel:+1-570-887-2239, fax:+1-570-887-3285	
Muhammad Z Khan, MD			

FOSTER LAW OFFICE

EXHIBIT NO. B12F

PAGE: 1 OF 53

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PRIVILEGED AND CONFIDENTIAL

July 14, 2020

Syracuse, NY OHO
P.O. Box 9045
London, KY 40742-9045

RE: Jennifer Brown
SSN: 132-58-2507

Dear Ladies and Gentlemen:

Enclosed herein please find the following medical records to be included in the above referenced file.

- Guthrie Clinic – 09/13/2019 through 06/10/2020

Should you have any questions or concerns, please do not hesitate to contact my law office.

Sincerely,
FOSTER LAW OFFICE

JONATHAN P. FOSTER, JR., ESQUIRE

JPF.Jr./jns



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/23/2019

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12/23/2019 - Office Visit in Sayre OB/GYN/Midwives

Clinic Notes

Progress Notes

Ripic, Shelli, CRNP at 12/23/2019 10:30 AM

Author: Ripic, Shelli, CRNP

Service: ---

Author Type: Nurse Practitioner

Filed: 12/23/2019 11:23 AM

Encounter Date: 12/23/2019

Status: Signed

Editor: Ripic, Shelli, CRNP (Nurse Practitioner)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 12/23/2019

Subjective

SUBJECTIVE:

Jennifer Lyn Brown is 43-y.o. female who presents for vaginal burning. Had 2 weeks of Amoxil 875 mg BID for sinusitis. Had vaginal itching. Took Diflucan x 2. Then used over-the-counter monistat. Then had labial irritation, used over-the-counter Vagisil. Now having burning of the tip of the labial fold. Patient is sexually active with same partner. No concern of STI. On oral contraceptive pill. Cycles controlled with oral contraceptive pill. No concern of pregnancy.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008

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GUTHRIE

Brown, Jennifer Lyn

PAGE: 3 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/23/2019

12/23/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/2/2017
Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/11/2018
Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR		
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD	N/A	8/13/2014
Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;		
• EGD	N/A	6/24/2016
Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• EGD	N/A	6/2/2017
Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• EGD	N/A	6/11/2018
Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR		
• EGD (GUTHRIE / NON GUTHRIE)		
• LAPAROSCOPIC CHOLECYSTECTOMY		2013
with liver biopsy		
• PR CLOSED RX TARSAL FX,EACH		
• PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY		12/10/2014
for obesity - Dr. Alley - RPH		
• PR REMOVAL GALLBLADDER		
• PR SHLDR ARTHROSCOP,PART ACROMIOPLAS	Left	5/24/2019
Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR		
• TONSILLECTOMY		11/26/07

Family History

Problem	Relation	Age of Onset
---------	----------	--------------



Brown, Jennifer Lyn

PAGE: 4 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/23/2019

12/23/2019 Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- Diabetes Mother
- Heart Mother
- Hypertension Mother
- Psychiatry Mother
- Anxiety
- Arthritis Mother
- Heart Disease Mother
- Kidney Disease Mother
- Diabetes Father
- Hypertension Father
- Genetic Father
- Marfan syndrome
- Heart Father
- ?Marfan's Syndrome
- Clotting Disorder Father
- Heart Disease Father
- Heart Paternal Uncle
- Aortic Dissection, Marfan's Syndrome
- Heart Disease Paternal Uncle
- Diabetes Maternal Grandfather
- Thyroid Disease Maternal Grandfather
- Macular Degeneration Paternal Grandmother
- Psychiatry Maternal Aunt
- ADHD
- Genetic Maternal Aunt
- Marfan syndrome
- Psychiatry Other
- ADHD
- Cancer Paternal Grandfather
- Glaucoma No family history
- Blindness No family history
- Other Eye Problems No family history
- Anesth Problems No family history

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.



Brown, Jennifer Lyn

EXHIBIT NO. B12F

MRN: 340616, DOB: 10/26/1976, Sex: F

PAGE: 5 OF 53

Visit date: 12/23/2019

12/23/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap Take 1 Cap by mouth DAILY.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluconazole (DIFLUCAN) 200 MG Oral Tab Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- folic acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 0.5 mL beneath the skin EVERY SATURDAY.
- mometasone (NASONEX) 50 MCG/ACT Nasal Suspension Spray 1 Spray in nose EVERY TWELVE HOURS.
- ondansetron (ZOFran) ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days



Brown, Jennifer Lyn

EXHIBIT NO. B12F

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/23/2019

12/23/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes



Brown, Jennifer Lyn

EXHIBIT NO. B12F

PAGE: 7 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/23/2019

12/23/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

Partners: Male
 Birth control/protection: Pill, Condom
 Comment: OCPs

Lifestyle

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file
 - Active member of club or organization: Not on file
 - Attends meetings of clubs or organizations: Not on file
 - Relationship status: Not on file
- Intimate partner violence
 - Fear of current or ex partner: Not on file
 - Emotionally abused: Not on file
 - Physically abused: Not on file
 - Forced sexual activity: Not on file

Other Topics

Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

All remaining review of systems was negative except for as noted in the history of present illness/subjective.

Objective

PHYSICAL EXAMINATION:

VITALS: BP 122/84 | Ht 5' 11" (1.803 m) | Wt 280 lb 11.2 oz (127.3 kg) | LMP 12/10/2019 | BMI 39.15 kg/m² Body mass index is 39.15 kg/m².

GENERAL: alert, oriented, no acute distress.

ABDOMEN: soft, non tender, without masses or organomegaly.

PELVIC: labia: Redness and a small fissure on the right labial fold, vagina: Vaginal findings are normal except for:, Vaginal discharge described as scant and white, cervix: Cervix is normal to inspection and without discharge., uterus: anteverted, mobile, non-tender, adnexa: No mass, fullness, tenderness.

Results for orders placed or performed in visit on 12/23/19

URINE DIP MANUAL (AMB POCT)

Result	Value	Ref Range
URINE GLUCOSE (POCT)	Negative	Negative mg/dl

921

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/23/2019

EXHIBIT NO. B12F

PAGE: 8 OF 53

12/23/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

URINE BILIRUBIN (POCT)	Negative	Negative
Urine Ketones (POCT)	Negative	Negative
URINE SPECIFIC GRAVITY (POCT)	1.030	1.005 - 1.030
URINE BLOOD (POCT)	Negative	Negative
URINE PH (POCT)	6.0	5.0 - 8.0
URINE PROTEIN (POCT)	Trace (A)	Negative mg/dl
URINE UROBILINOGEN (POCT)	0.2	0.2 - 1.0 mg/dl
URINE NITRITES (POCT)	Negative	Negative
URINE LEUKOCYTES (POCT)	Negative	Negative Cells/uL

*Note: Due to a large number of results and/or encounters for the requested time period, some results have not been displayed. A complete set of results can be found in Results Review.

ASSESSMENT:

	ICD-9- CM	ICD-10- CM	
1. Vaginal burning	625.8	N94.9	URINE DIP MANUAL (AMB POCT) CANDIDA / GARD / TRIC DNA PROBE CANDIDA / GARD / TRIC DNA PROBE

Plan

PLAN:

All questions answered.

Educational material distributed..

Encouraged use of coconut oil to the labial skin. Stop Vagisil. Use limited soap.

Follow-up with results.

Author: Shelli Ripic, CRNP 12/23/2019 11:23

Electronically signed by Ripic, Shelli, CRNP at 12/23/2019 11:23 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice

Clinic Notes

Progress Notes

Gillan, Michael F, DO at 12/20/2019 2:00 PM

Author: Gillan, Michael F, DO
Filed: 12/22/2019 12:53 PM
Editor: Gillan, Michael F, DO (Physician)

Service: —
Encounter Date: 12/20/2019

Author Type: Physician
Status: Signed

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 12/20/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Leg Pain

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.
HPI

1. Here with left knee pain:
 - Behind the left knee.
 - Feels swollen.
 - No redness.
 - Worse when knee leg is extended, resolves with flexion.
 - Does not awaken her from sleep.
 - Does not radiate.
 - No injury or inciting event.
 - Has not tried any medications.
 - No other new joint pains or issues.
2. Recent sinus infection.
 - Had sore throat, congestion, ear pain.
 - Treated with antibiotic with resolution with exception of some sinus discomfort.
 - Significantly improved.
 - Does not wish to have another antibiotic, but is looking for a nasal spray to try.

Denies any other issues or concerns.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
• CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	

GUTHRIESM

Brown, Jennifer Lyn

PAGE: 10 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
ADHD		
• Genetic	Maternal Aunt	
Marfan syndrome		
• Psychiatry	Other	



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

ADHD

- | | |
|----------------------|----------------------|
| • Cancer | Paternal Grandfather |
| • Glaucoma | No family history |
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluconazole (DIFLUCAN) 200 MG Oral Tab	Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 0.5 mL beneath the skin EVERY SATURDAY.
• mometasone (NASONEX) 50 MCG/ACT Nasal Suspension	Spray 1 Spray in nose EVERY TWELVE HOURS.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm
• sulfasalazine (AZULFIDINE) 500 MG Oral Tab	Take 3 Tabs by mouth TWICE DAILY.
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days



Brown, Jennifer Lyn

PAGE: 12 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen

- Bee Stings [Bee Sting]
- Oxycodone
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Hives
Rash
Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)**Clinic Notes (continued)**

• Social connections

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

• Intimate partner violence

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics

Concern

• Not on file

Social History/Narrative*August 2016: Works at Guthrie GI department. Lives with husband, has no children.***REVIEW OF SYSTEMS:****ROS**

A comprehensive review of systems was conducted with the patient and is negative unless noted above.

Objective**PHYSICAL EXAM:**VITALS: BP 132/90 (BP Location: Right arm, Patient Position: Sitting) | Pulse 88 | Temp 99 °F (37.2 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 280 lb (127 kg) | SpO2 98% | BMI 39.05 kg/m² Body mass index is 39.05 kg/m².**Physical Exam****Constitutional:**

Appearance: Normal appearance.

HENT:

Head: Normocephalic and atraumatic.

Comments: **Mild sinus pressure to palpation.**

Right Ear: Tympanic membrane, ear canal and external ear normal. There is no impacted cerumen.

Left Ear: Tympanic membrane, ear canal and external ear normal. There is no impacted cerumen.

Mouth/Throat:

Mouth: Mucous membranes are moist.

Pharynx: No oropharyngeal exudate or posterior oropharyngeal erythema.

Eyes:

Extraocular Movements: Extraocular movements intact.

Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulses: Normal pulses.

Heart sounds: Normal heart sounds. No murmur. No friction rub. No gallop.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing, rhonchi or rales.



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Chest:

Chest wall: No tenderness.

Musculoskeletal:

Left knee: She exhibits swelling (behind knee, suspect this is baker's cyst). She exhibits normal range of motion, no effusion, normal alignment, no LCL laxity, normal patellar mobility and no bony tenderness. No tenderness found. No medial joint line, no lateral joint line, no MCL, no LCL and no patellar tendon tenderness noted.

Lymphadenopathy:

Cervical: No cervical adenopathy.

Skin:

General: Skin is warm and dry.

Neurological:

Mental Status: She is alert.

Psychiatric:

Mood and Affect: Mood normal.

Behavior: Behavior normal.

Thought Content: Thought content normal.

Judgment: Judgment normal.

ASSESSMENT / IMPRESSION:

	CD-9-CM	CD-10-CM	
1. Sinus pressure	478.19	J34.89	mometasone (NASONEX) 50 MCG/ACT Nasal Suspension
2. Pain and swelling of knee, left	719.46	M25.562	US LOWER EXTREMITY NON VASCULAR LIMITED LEFT
		M25.462	

Plan

1. Sinus pressure:

- Completed antibiotic therapy.
- Nearly resolved.
- May use nasal saline and/or nasal steroid.
- Follow up if symptoms worsen or fail to resolve.

2. Pain and swelling behind left knee:

- No overlying skin changes to suggest infection.
- Appears to be baker's cyst.
- Will confirm with ultrasound.
- Follow up after testing, sooner as needed.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

Nasal Spray twice daily for at least two weeks.

Ultrasound of the left knee.



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/20/2019

12/20/2019 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

I will contact you with the results.

Michael F Gillan, DO

Author: Michael F Gillan, DO 12/22/2019 12:25

Electronically signed by Gillan, Michael F, DO at 12/22/2019 12:53 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/18/2019

12/18/2019: Office Visit in Sayre Gastroenterology

Clinic Notes

Progress Notes

Yousef, Mohammad, MD at 12/18/2019 2:40 PM

Author: Yousef, Mohammad, MD

Service: —

Author Type: Resident

Filed: 12/18/2019 3:36 PM

Encounter Date: 12/18/2019

Status: Cosign Needed

Editor: Yousef, Mohammad, MD (Resident)

Cosign Required: Yes

Cosigner: —

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 12/18/2019

REFERRING PRACTITIONER: Self-Referred

PRIMARY CARE PROVIDER: Gillan, Michael F

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up
New to you
- Diarrhea
- Abdominal Pain
right side

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female with a past medical history of Crohn's disease who presents to clinic today to discuss her medications and with right lower quadrant abdominal pain. In regards to her Crohn's disease from record review it appears she was diagnosed in June 2016 although she did have a colonoscopy in June 2015 with ulcers in the terminal ileum. She was initially treated with Remicade the time of diagnosis until October 2016 but developed a systemic reaction with pruritis. She is then took Humira until 2018 but developed drug-induced lupus secondary to the Humira and had a switch to Stelara which she takes 1 time every 8 weeks now last dose was November 11 of this year. Of note the patient also has rheumatoid arthritis for which she takes methotrexate half a milliliter weekly and sulfasalazine 3 tabs twice daily. Her last EGD and colonoscopy were performed in June 2018 and at that time procedure reports showed above procedures appear relatively normal. Biopsies show focally active colitis in the sigmoid without significant architectural distortion, crypt abscesses, or granulomas. Regards to her pain the patient states she has been having nagging right lower quadrant pain which she rates at about a 3-4 out of 10 constant not aggravated or alleviated by anything including eating or having a bowel movement. She states her bowel movements have been pretty regular although she does have intermittent diarrhea. There nothing persistent. Denies any evidence of hematochezia, bright red blood per rectum, melena, fever, nausea, vomiting. She is recently discussing initiation of Xeljanz therapy with her rheumatologist for her RA and was wondering if she could perhaps take the Xeljanz as monotherapy for Crohn's as well. However with her newly found right lower quadrant pain there is concern for potential active versus worsening disease process.



Brown, Jennifer Lyn

EXHIBIT NO. B12F

PAGE: 17 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/18/2019

12/18/2019 - Office Visit in Sayre Gastroenterology (continued)

Clinic Notes (continued)

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluconazole (DIFLUCAN) 200 MG Oral Tab	Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 0.5 mL beneath the skin EVERY SATURDAY.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/18/2019

12/18/2019 - Office Visit in Sayre Gastroenterology (continued)

Clinic Notes (continued)

- Probiotic Product (VSL#3) Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm
- sulfasalazine (AZULFIDINE) Take 3 Tabs by mouth TWICE DAILY.
500 MG Oral Tab
- Syringe/Needle, Disp, 25G X Inject 1 mL within a muscle EVERY THIRTY
1-1/2" 5 ML Does not apply DAYS. Vitamin B12 IM
Misc
- Syringe/Needle, Disp, 25G X Inject 1 mL within a muscle EVERY THIRTY
1-1/2" 5 ML Does not apply DAYS. Inject 1 mL of Vit B12 IM every 30 days
Misc
- Ustekinumab 90 MG/ML Inject 90 mg beneath the skin AS DIRECTED.
Subcutaneous Solution Inject every 8 weeks. Indications: Crohn's
Prefilled Syringe Disease
- venlafaxine (EFFEXOR XR) Take 1 Cap by mouth DAILY.
150 MG Oral CAPSULE SR
24 HR
- venlafaxine (EFFEXOR XR) Take 2 Caps by mouth DAILY.
37.5 MG Oral CAPSULE SR
24 HR

Current Facility-Administered Medications

- Medication
- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

REVIEW OF SYSTEMS:

All remaining review of systems was negative.

Objective

PHYSICAL EXAMINATION:

VITALS: BP 126/88 (BP Location: Left arm, Patient Position: Sitting) | Pulse 88 | Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m² Body mass index is 39.89 kg/m².

General appearance: alert, no acute distress

Eyes: conjunctivae and sclerae appear normal

Throat: lips, mucosa, and tongue normal.

Lungs: effort appears normal, no stridor appreciated

Abdomen: soft, non-tender; bowel sounds normal; no masses, no organomegaly.

Skin: no rashes appreciated, no jaundice.

Neurologic: Mental status: alert, oriented, thought content appropriate, no asterixis.

Extremities: no lower extremity edema, no muscle wasting appreciated.


GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/18/2019

EXHIBIT NO. B12F**PAGE: 19 OF 53****12/18/2019 - Office Visit in Sayre Gastroenterology (continued)****Clinic Notes (continued)****IMPRESSION:**

	ICD-9-	ICD-10-	
	CM	CM	
1. Crohn's disease of colon without complication (HCC)	555.1	K50.10	CALPROTECTIN, STOOL
2. RLQ abdominal pain	789.03	R10.31	COLONOSCOPY DIAGNOSTIC

PLAN:

In light of the patient's right lower quadrant pain and history of ulcerative colitis specifically with terminal ileum ulcers will obtain colonoscopy with biopsies. We will also obtain a stool calprotectin today she had a recent ESR and CRP completed which are within normal limits. I discussed all the following with the patient and she is in agreement based on the stool calprotectin and results of the biopsies will discuss potentially decreasing her therapy to budesonide and/or different treatment options. Patient will follow-up with either Dr. Georgetown or myself following her procedure.

Author: Mohammad Yousef, MD 12/18/2019 15:29

Electronically signed by Yousef, Mohammad, MD at 12/18/2019 3:36 PM

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/11/2019

12/11/2019 - Lab in Sayre Laboratory

Labs

CYCLIC CITRULLINE PEPTIDE ANTIBODY IGG [163840182] (Final result)

Status: Completed

Electronically signed by: Freeman, James, MD on 12/11/19 1525

Ordering user: Freeman, James, MD 12/11/19 1525

Authorized by: Freeman, James, MD

Frequency: Routine 12/11/19 -

Quantity: 1

Instance released by: Ray, Savanna 12/11/2019 3:42 PM

Diagnoses

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732]

Ordering provider: Freeman, James, MD

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
QU19-345Q0303	Blood	Blood - Veni	Ray, Savanna 12/11/19 1545

CYCLIC CITRULLINE PEPTIDE ANTIBODY IGG [163840182]

Resulted: 12/16/19 0156, Result status: Final result

Ordering provider: Freeman, James, MD 12/11/19 1542

Order status: Completed

Filed by: Quest, Results Interface 12/16/19 0200

Collected by: Ray, Savanna 12/11/19 1545

Resulting lab: QUEST DIAGNOSTICS

Components

Component	Value	Reference Range	Flag	Lab
CYCLIC CITRULLINE PE	<16	<20 UNITS	—	36
Comment:				

CLASSIFICATION UNITS INTERPRETATION

NEGATIVE <20 A NEGATIVE RESULT INDICATES NO
CCP IGG ANTIBODY PRESENT OR
LEVELS BELOW THE ASSAY CUTOFF.

WEAK POSITIVE 20-39

A POSITIVE SEMI-QUANTITATIVE

MODERATE POSITIVE 40-59 RESULT INDICATES THE PRESENCE OF

CCP IGG ANTIBODIES OF INCREASING

STRONG POSITIVE >59 LEVELS.

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST	Unknown	Unknown	875 GREENTREE RD	09/26/11 1434 - Present
	DIAGNOSTICS			4 PARKWAY CENTER	
				PITTSBURGH PA	
				15220	

Indications

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732 (ICD-10-CM)]

RHEUMATOID FACTOR [163840183] (Final result)

Status: Completed

Electronically signed by: Freeman, James, MD on 12/11/19 1525

Ordering user: Freeman, James, MD 12/11/19 1525

Authorized by: Freeman, James, MD

Frequency: Routine 12/11/19 -

Quantity: 1

Instance released by: Ray, Savanna 12/11/2019 3:42 PM

Diagnoses

Ordering provider: Freeman, James, MD

Ordering mode: Standard

Class: Guthrie

Lab status: Final result


GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/11/2019

12/11/2019 - Lab in Sayre Laboratory (continued)
Labs (continued)

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732]

Specimen Information

ID	Type	Source	Collected By
GC19-345C1259	Blood	Blood - Veni	Ray, Savanna 12/11/19 1545

RHEUMATOID FACTOR [163840183] (Normal)

Resulted: 12/11/19 1734, Result status: Final result

Ordering provider: Freeman, James, MD 12/11/19 1542

Order status: Completed

Filed by: Interface, Lab Orders 12/11/19 1734

Collected by: Ray, Savanna 12/11/19 1545

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
Rheumatoid Factor	11.0	<15.0 IU/ml	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732 (ICD-10-CM)]

C-REACTIVE PROTEIN [163840184] (Final result)

Status: Completed

Electronically signed by: Freeman, James, MD on 12/11/19 1522

Ordering user: Freeman, James, MD 12/11/19 1522

Authorized by: Freeman, James, MD

Ordering provider: Freeman, James, MD

Ordering mode: Standard

Frequency: Routine 12/11/19 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Ray, Savanna 12/11/2019 3:42 PM

Diagnoses

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732]

Specimen Information

ID	Type	Source	Collected By
GC19-345C1260	Blood	Blood - Veni	Ray, Savanna 12/11/19 1545

C-REACTIVE PROTEIN [163840184] (Normal)

Resulted: 12/11/19 1650, Result status: Final result

Ordering provider: Freeman, James, MD 12/11/19 1542

Order status: Completed

Filed by: Interface, Lab Orders 12/11/19 1650

Collected by: Ray, Savanna 12/11/19 1545

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
C-Reactive Protein	<0.50	<1.00 mg/dl	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications
935



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/11/2019

12/11/2019 - Lab in Sayre Laboratory (continued)

Labs (continued)

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732 (ICD-10-CM)]

SEDIMENTATION RATE [163840185] (Final result)

Electronically signed by: Freeman, James, MD on 12/11/19 1522

Status: Completed

Ordering user: Freeman, James, MD 12/11/19 1522

Ordering provider: Freeman, James, MD

Authorized by: Freeman, James, MD

Ordering mode: Standard

Frequency: Routine 12/11/19 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Ray, Savanna 12/11/2019 3:42 PM

Diagnoses

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732]

Specimen Information

ID	Type	Source	Collected By
GC19-345H0731	Blood	Blood - Veni	Ray, Savanna 12/11/19 1545

SEDIMENTATION RATE [163840185] (Normal)

Resulted: 12/11/19 1637, Result status: Final result

Ordering provider: Freeman, James, MD 12/11/19 1542

Order status: Completed

Filed by: Interface, Lab Orders 12/11/19 1637

Collected by: Ray, Savanna 12/11/19 1545

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
ESR	19	0 - 20 MM/HR	—	GMG

Comment: Methodology was changed 6/26/19. Please note updated reference range.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC) [M05.731, M05.732 (ICD-10-CM)]



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/11/2019

12/11/2019 Office Visit in Sayre Rheumatology

Clinic Notes

Progress Notes

Freeman, James, MD at 12/11/2019 2:20 PM

Author: Freeman, James, MD

Filed: 1/8/2020 1:18 PM

Editor: Freeman, James, MD (Physician)

Service: —

Encounter Date: 12/11/2019

Author Type: Physician

Status: Signed

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 12/11/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.

HPI

Follow up for a mix of enteropathic arthritis, Crohn's, positive RF, and fibromyalgia. Currently on SSZ 1.5gm bid, MTX 12.5mg weekly, stelara q3months, and amitriptyline. Still with widespread aches and pains, but not a lot of joint swelling. Morning stiffness a half hour. Sleep better on the amitriptyline. We reduced the dose of methotrexate last visit without apparent worsening of symptoms. No trouble tolerating these medications, though she is getting over a sinus infection. Not working and applying for disability.

Bowels are doing well without diarrhea, bloody stool, cramps, or weight loss. Due for labs.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/11/2019

12/11/2019 Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
ADHD		
• Genetic	Maternal Aunt	
Marfan syndrome		
• Psychiatry	Other	
ADHD		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG	Take 1 Tab by mouth THREE TIMES DAILY AS
Oral Tab	NEEDED (increased anxiety). Max Daily Amount: 0.75



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/11/2019

12/11/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- | | |
|--|---|
| | mg. |
| • amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab | Take 1 Tab by mouth EVERY BEDTIME. |
| • amoxicillin-clavulanic acid (AUGMENTIN) 875-125 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY for 10 days. |
| • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE) 600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • fluconazole (DIFLUCAN) 200 MG Oral Tab | Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10 |
| • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. |
| • foliC acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc | 1 Each by Does not apply route EVERY 7 DAYS. |
| • levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab | Take 1 Tab by mouth DAILY. |
| • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution | Inject 0.5 mL beneath the skin EVERY SATURDAY. |
| • ondansetron (ZOFran ODT) 8 MG Oral TABLET DISPERSIBLE | Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG Oral Tab EC | Take 1 Tab by mouth DAILY. |
| • Probiotic Product (VSL#3) Oral Cap | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm |
| • sulfasalazine (AZULFIDINE) 500 MG Oral Tab | Take 3 Tabs by mouth TWICE DAILY. |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days |
| • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe | Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease |
| • venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR | Take 1 Cap by mouth DAILY. |
| • venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR | Take 2 Caps by mouth DAILY. |

Current Facility-Administered Medications

Medication



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/11/2019

12/11/2019 - Office Visit in Sayre Rheumatology (continued)**Clinic Notes (continued)**

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History**Socioeconomic History**

- Marital status: Separated
 - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file
 - Active member of club or organization: Not on file
 - Attends meetings of clubs or organizations: Not on file
 - Relationship status: Not on file
- Intimate partner violence


GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/11/2019

12/11/2019 - Office Visit in Sayre Rheumatology (continued)
Clinic Notes (continued)

Fear of current or ex partner: Not on file
 Emotionally abused: Not on file
 Physically abused: Not on file
 Forced sexual activity: Not on file

Other Topics: Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative.

Eyes: Negative for blurred vision, photophobia, pain and redness.

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: Negative for abdominal pain, blood in stool, constipation, diarrhea, heartburn, nausea and vomiting.

Musculoskeletal: Positive for back pain, joint pain and myalgias.

Skin: Negative for rash.

Objective
PHYSICAL EXAM:

VITALS: BP 130/90 | Ht 5' 11" (1.803 m) | Wt 286 lb (129.7 kg) | BMI 39.89 kg/m² Body mass index is 39.89 kg/m².

Physical Exam
Constitutional:

Appearance: She is obese.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulmonary:

Breath sounds: Normal breath sounds.

Abdominal:

Palpations: Abdomen is soft.

Musculoskeletal: Normal range of motion.

General: No swelling.

Comments: **Widespread trigger point tenderness**

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM
1. Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC)	714.0	M05.731
		M05.732
2. Enteropathic arthritis	713.1	M07.60
3. Fibromyalgia	729.1	M79.7

Plan

941



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/11/2019

12/11/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

Continue current therapy

Patient will discuss xeljanz with GI which might be more effective for her RA than stelara.

RV 3 months

RV 3 months

Author: James Freeman, MD 12/11/2019 15:21

Electronically signed by Freeman, James, MD at 1/8/2020 1:18 PM

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic

Clinic Notes

Progress Notes

Braund, Lisa, FNP-C at 12/5/2019 9:30 AM

Author: Braund, Lisa, FNP-C

Service: —

Author Type: Nurse Practitioner

Filed: 12/5/2019 9:52 AM

Encounter Date: 12/5/2019

Status: Signed

Editor: Braund, Lisa, FNP-C (Nurse Practitioner)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 12/5/2019

Chief Complaint

Patient presents with

- Cough
- Congestion
- Sore Throat

HPI: Jennifer Lyn Brown is a 43-y.o. female who presents to the Guthrie walk in office today for complaints of thick colored sinus congestion/mucous, post nasal drip, ear pressure, sore throat, cough for the past week

History of sinus/allergy/lung issues: sinus issues

Meds currently taking: Alka seltzer cold medication

Smoking history: denies

On methotrexate

Denies fever, cp, sob, abdominal pain, n/v/d/c

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	

GUTHRIESM

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic (continued)

Clinic Notes (continued)

- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/2/2017
Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/11/2018
Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR		
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD	N/A	8/13/2014
Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;		
• EGD	N/A	6/24/2016
Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• EGD	N/A	6/2/2017
Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• EGD	N/A	6/11/2018
Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR		
• EGD (GUTHRIE / NON GUTHRIE)		
• LAPAROSCOPIC CHOLECYSTECTOMY		2013
with liver biopsy		
• PR CLOSED RX TARSAL FX,EACH		
• PR LAP, GAST RESTRICT PROC, LONGITUDINAL		12/10/2014



Brown, Jennifer Lyn

PAGE: 31 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic (continued)

Clinic Notes (continued)

GASTRECTOMY

for obesity - Dr. Alley - RPH

- PR REMOVAL GALLBLADDER

- PR SHLDR ARTHROSCOP, PART ACROMIOPLAS Left 5/24/2019

Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION,
DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR

- TONSILLECTOMY 11/26/07

Outpatient Medications Marked as Taking for the 12/5/19 encounter
(Office Visit) with Braund, Lisa, FNP-C

Medication	Sig	Dispense	Refill
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.	15 Tab	0
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.	90 Tab	0
• amoxicillin-clavulanic acid (AUGMENTIN) 875-125 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY for 10 days.	20 Tab	0
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.	90 Tab	1
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.	60 Tab	5
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.	90 Cap	3
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.	42 Tab	0
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).	1 Each	3
• fluconazole (DIFLUCAN) 200 MG Oral Tab	Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on	2 Tab	0



GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic (continued)

Clinic Notes (continued)

	day 10		
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.	1 Bottle	0
• folic acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.	90 Tab	3
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.	100 Each	0
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.	84 Tab	3
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.	90 Tab	1
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.	30 Tab	0
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 0.5 mL beneath the skin EVERY SATURDAY.	12 mL	0
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.	30 Tab	1
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.	90 Tab	1
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm	60 Cap	3
• sulfasalazine (AZULFIDINE) 500 MG Oral Tab	Take 3 Tabs by mouth TWICE DAILY.	120 Tab	2
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM	12 Each	0
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days	12 Each	0



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic (continued)
Clinic Notes (continued)

- Ustekinumab 90 MG/ML Inject 90 mg 1 Syringe 5
Subcutaneous Solution beneath the skin
Prefilled Syringe AS DIRECTED.
Inject every 8
weeks.
Indications:
Crohn's Disease
- venlafaxine (EFFEXOR XR) Take 1 Cap by 90 Cap 1
150 MG Oral CAPSULE SR mouth DAILY.
- 24 HR
- venlafaxine (EFFEXOR XR) Take 2 Caps by 180 Cap 1
37.5 MG Oral CAPSULE SR mouth DAILY.
- 24 HR

Current Facility-Administered Medications for the 12/5/19 encounter (Office Visit) with Braund, Lisa, FNP-C

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• saline (OCEAN) 2 nasal spray 0.65 %	Spray	Nasal	Q2H PRN	Braslow, Matthew Lim, DO		

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

ROS: Reviewed in HPI and pertinent positives noted above, remaining are negative if not otherwise stated.

PHYSICAL EXAM:
OBJECTIVE:

BP 138/92 Pulse 85 Temp 98.5 °F (36.9 °C) (Tympanic) Resp 16 SpO2 96%

GENERAL: Alert, appears mildly ill & tired.

EYES: Conjunctiva without erythema or drainage.

EARS: Bilateral canals healthy and clear. Tympanic membrane's erythematous on right with mild effusion. Left retracted

NOSE: Thick purulent mucoid drainage bilateral nares and moderate inferior turbinate hypertrophy.

FACE: No facial swelling. + pain over maxillary sinuses with palpation.

ORAL CAVITY: Pink & moist oral mucosa. Uvula midline. No trismus. Mild erythema but without exudate. Thick purulent drainage on posterior pharyngeal wall, + cobblestoning.

NECK: No anterior, posterior, or supraclavicular lymphadenopathy. Trachea midline. No stridor.

CHEST/LUNGS: Resps easy and unlabored. No rales, rhochi.

HEART: Regular rate and rhythm. No murmurs appreciated



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 12/5/2019

12/05/2019 - Office Visit in Sayre ACT Clinic (continued)

Clinic Notes (continued)

INTEGUMENTARY: Skin pink, warm, without edema, acute rashes or lesions noted.

ASSESSMENT:

	ICD-9-	ICD-10-
	CM	CM
1. Right otitis media with effusion	381.4	H65.91
2. Long term current use of immunosuppressive drug	V58.69	Z79.899
3. Acute bacterial rhinosinusitis	461.9	J01.90 B96.89

PLAN:

Patient Instructions

Prescriptions ordered today and eprescribed to your pharmacy:

Augmentin 875mg twice daily x 10 days: With food

Diflucan as needed

Follow your rheumatologist recommendation for your next methotrexate dose while you are ill

Recommended to pick up to help with your symptoms/diagnosis today:

Saline nasal spray for nasal congestion

Mucinex (guaifenesin: long acting) or robatussin (guaifenesin: short acting) for cough/expectorant

Tylenol every 4 hours as needed for pain/fever;

May consider using a probiotic or eat yogurt with "live cultures/acidophilus" to help with GI upset/diarrhea while taking any antibiotic.

Fluids.

Rest

Humidification

Recheck as needed if symptoms persist or worsen after 4-7 days.

Thank you for choosing the Sayre Walk In Clinic for your needs today!

You have been evaluated at a Walk-In Clinic. The examination and treatment you received is given on an acute basis only. No ongoing doctor-patient relationship was established by this visit today. It is not a substitute for complete medical care. It is important that you be rechecked by your primary care provider as directed. We can assist you in establishing with a primary care provider if you do not have one.

Our office number is 570.887.2383 if you have any questions or concerns.

Lisa Braund, FNP-C

**GUTHRIE**

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 12/5/2019

EXHIBIT NO. B12F**PAGE: 35 OF 53****12/05/2019 - Office Visit in Sayre ACT Clinic (continued)****Clinic Notes (continued)**

Lisa Braund, FNP-C 12/5/2019 09:51

Electronically signed by Braund, Lisa, FNP-C at 12/5/2019 9:52 AM

**GUTHRIE**

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives**Clinic Notes****Progress Notes****Ripic, Shelli, CRNP at 10/3/2019 11:00 AM**

Author: Ripic, Shelli, CRNP

Service: —

Author Type: Nurse Practitioner

Filed: 10/3/2019 11:36 AM

Encounter Date: 10/3/2019

Status: Signed

Editor: Ripic, Shelli, CRNP (Nurse Practitioner)

PATIENT: Jennifer Lyn Brown**MRN:** 340616**DOB:** 10/26/1976**DATE OF SERVICE:** 10/3/2019**Subjective****SUBJECTIVE:**

Jennifer Lyn Brown is 42-y.o. female who presents for routine women's health maintenance. Patient reports no gynecologic complaints. Cycles monthly with limited flow.

The patient denies abdominal or flank pain, anorexia, n/v or dysphagia, change in BM or black/bloody stools or weight loss. History of crohn's, has loose stool.

She denies abnormal vaginal bleeding, discharge, unusual pelvic pain. On oral contraceptive pill for contraception. Plans tubal removal.

Denies dysuria, frequency/urgency or hematuria.

Patient denies any exertional chest pain, dyspnea, palpitations, or edema. History of arthritis. Has some difficulty with activity.

There is no personal history of breast cancer. She denies new lumps, breast pain or nipple discharge.

Nursing Notes:**Simmons, Mary 10/3/2019 11:08 AM Signed****PATIENT:** Jennifer Lyn Brown**MRN:** 340616**DOB:** 10/26/1976**DATE OF SERVICE:** 10/3/2019**Chief Complaint****Patient presents with**

- Annual

MENARCHE - 13 y/o**CONTRACEPTION** - OCP**LAST PAP** - 4.5.18**MAMMO** - 6.26.19**DEXA** - N/A**COLONOSCOPY** - 6.11.18**Author:** Mary Simmons 10/3/2019 11:00



GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS CT 2005	5/23/2005
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
• irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
• Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/2/2017
Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR		
• COLONOSCOPY	N/A	6/11/2018
Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR		



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- COLONOSCOPY DIAGNOSTIC
- EGD 2002
- EGD N/A 8/13/2014
Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;
- EGD N/A 6/24/2016
Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/2/2017
Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR
- EGD N/A 6/11/2018
Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR
- EGD (GUTHRIE / NON GUTHRIE)
- LAPAROSCOPIC CHOLECYSTECTOMY 2013
with liver biopsy
- PR CLOSED RX TARSAL FX, EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL 12/10/2014
GASTRECTOMY
for obesity - Dr. Alley - RPH
- PR REMOVAL GALLBLADDER
- PR SHLDR ARTHROSCOP, PART ACROMIOPLAS Left 5/24/2019
Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR
- TONSILLECTOMY 11/26/07

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- | | |
|------------------------|----------------------|
| • Heart Disease | Paternal Uncle |
| • Diabetes | Maternal Grandfather |
| • Thyroid Disease | Maternal Grandfather |
| • Macular Degeneration | Paternal Grandmother |
| • Psychiatry | Maternal Aunt |
| ADHD | |
| • Genetic | Maternal Aunt |
| Marfan syndrome | |
| • Psychiatry | Other |
| ADHD | |
| • Cancer | Paternal Grandfather |
| • Glaucoma | No family history |
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Medications

- | Medication | Sig |
|--|---|
| • ALPRAZolam (XANAX) 0.25 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg. |
| • amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab | Take 1 Tab by mouth EVERY BEDTIME. |
| • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE) 600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3) 1000 units Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution | Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days |
| • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. |
| • folic acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc | 1 Each by Does not apply route EVERY 7 DAYS. |
| • levonorgestrel-ethinyl | Take 1 Tab by mouth DAILY. |



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

- estradiol triphasic
(LEVONEST) Oral Tab
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- [START ON 10/5/2019] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 0.5 mL beneath the skin EVERY SATURDAY.
- ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

- Medication
- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

**GUTHRIE**

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)**Clinic Notes (continued)****Social History****Socioeconomic History**

- Marital status: Separated
 - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs:
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use:
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity:
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections:
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file
 - Active member of club or organization: Not on file
 - Attends meetings of clubs or organizations: Not on file
 - Relationship status: Not on file
- Intimate partner violence:



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)

Fear of current or ex partner: Not on file
Emotionally abused: Not on file
Physically abused: Not on file
Forced sexual activity: Not on file

Other Topics Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

All remaining review of systems was negative except for as noted in the history of present illness/subjective.

Objective

PHYSICAL EXAMINATION:

VITALS: BP 140/90 | Ht 5' 11" (1.803 m) | Wt 281 lb 6.4 oz (127.6 kg) | LMP 09/05/2019 | BMI 39.25 kg/m² Body mass index is 39.25 kg/m².

GENERAL: alert, oriented, no acute distress.

NECK: no mass, no adenopathy, no thyromegaly.

LUNGS: clear to auscultation bilaterally.

HEART: regular rhythm, no murmurs.

EXTREMITIES: no clubbing, cyanosis, or edema.

BREAST: Inspection negative. No nipple discharge or bleeding. No masses or tenderness. No axillary nodes or masses.

ABDOMEN: soft, non tender, without masses or organomegaly.

BACK: negative.

PELVIC: labia: normal, vagina: No prolapse or lesions, Vaginal findings are normal except for: Atrophic appearing mucosa which is pale and dry., cervix: Cervix is normal to inspection and without discharge., uterus: anteverted, mobile, non-tender, adnexa: No mass, fullness, tenderness.

ASSESSMENT:

	ICD-9-CM	ICD-10-CM	
1. Visit for screening mammogram	V76.12	Z12.31	MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Plan

PLAN:

All questions answered.

Will call for appointment with MD for tubal removal.

Plans to continue her oral contraceptive pill until that time.

Follow-up 12 months.

Author: Shelli Ripic, CRNP 10/3/2019 11:35

Electronically signed by Ripic, Shelli, CRNP at 10/3/2019 11:36 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/3/2019

10/03/2019 - Office Visit in Sayre OB/GYN/Midwives (continued)

Clinic Notes (continued)



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/2/2019

10/02/2019 - Office Visit in Sayre Rheumatology

Clinic Notes

Progress Notes

Avetisova, Mariam, MD at 10/2/2019 3:40 PM

Author: Avetisova, Mariam, MD

Service: —

Author Type: Resident

Filed: 10/4/2019 10:46 AM

Encounter Date: 10/2/2019

Status: Signed

Editor: Avetisova, Mariam, MD (Resident)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 10/2/2019

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 42-y.o. female.

HPI

Jennifer Lyn Brown is a 42-y.o. female with PMH of RA, RF only slightly positive Rheumatoid arthritis and HLA B 27 positive (2008), Gastric sleeve surgery (2013), Crohn's disease, Started on Remicade 7/2016 but was switched to humira after she developed skin rash and allergy to remicade. Of note, patient developed drug induced lupus on Humira, and then changed to Ustekinumab by GI, methotrexate 25mg SC Q weekly. She states that she has widespread musculoskeletal pain involving the upper back and spine, neck, shoulders and the lower back and spine (including the buttocks), associated with fatigue and sleep disturbances. Her Crohn's symptoms have been well controlled. Recent ESR was normal.

Past Medical History:

Diagnosis	Date
Anal fissure	1/2013
Anxiety	
Attention deficit	
Back ache	3/18/2014
Calcaneal spur	6/30/2008
Cherry angioma	8/9/2016
Cholecystitis	
CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
Crohn disease (HCC)	
Depression	1/20/2014
Endocrine problem	
Epicondylitis elbow, medial	10/7/2008
Fatty liver	
Fibromyalgia	8/20/2014
Fractures	
Gastroparesis	
irritable bowel syndrome	
GERD (gastroesophageal reflux disease)	10/7/2008
HTN (hypertension), benign	10/7/2008
Hypertension	



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/2/2019

10/02/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
<i>Anxiety</i>		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		
• Heart	Father	
<i>?Marfan's Syndrome</i>		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
<i>Aortic Dissection, Marfan's Syndrome</i>		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
<i>ADHD</i>		
• Genetic	Maternal Aunt	
<i>Marfan syndrome</i>		
• Psychiatry	Other	
<i>ADHD</i>		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Current Outpatient Medications

Medication	Sig
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Brown, Jennifer Lyn

PAGE: 46 OF 53

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/2/2019

10/02/2019 Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab Take 1 Tab by mouth EVERY BEDTIME.
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 1000 units Oral Cap Take 1 Cap by mouth DAILY.
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution Inject 1 mL within a muscle ONE TIME for 64 days. Every 30 days
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- folic acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply 1 Each by Does not apply route EVERY 7 DAYS.
- Misc
- levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab Take 1 Tab by mouth DAILY.
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- [START ON 10/5/2019] methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution Inject 0.5 mL beneath the skin EVERY SATURDAY.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC Take 1 Tab by mouth DAILY.
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn.
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Vitamin B12 IM
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

Medication

960



GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/2/2019

10/02/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History

Socioeconomic History

- Marital status: Separated
 - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs:
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity:
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections:
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file
 - Active member of club or organization: Not on file
 - Attends meetings of clubs or organizations: Not on file
 - Relationship status: Not on file
- Intimate partner violence:

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 10/2/2019

10/02/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

Fear of current or ex partner:	Not on file
Emotionally abused:	Not on file
Physically abused:	Not on file
Forced sexual activity:	Not on file

Other Topics	Concern
--------------	---------

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:**ROS**

A full 12 point review of systems was negative or as noted in the History of Present Illness.

Objective**PHYSICAL EXAM:**

VITALS: BP 118/72 | Ht 5' 11" (1.803 m) | Wt 278 lb (126.1 kg) | LMP 09/05/2019 | BMI 38.77 kg/m² Body mass index is 38.77 kg/m².

Physical ExamHEENT:

Head: Normocephalic and atraumatic.

Nose: Nose normal.

Eyes:

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Neck:

Musculoskeletal: Normal range of motion and neck supple.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Heart sounds: Normal heart sounds. No murmur.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing or rales.

Chest:

Chest wall: No tenderness.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no tenderness.

Musculoskeletal: Normal range of motion.

General: Tenderness present. No swelling, deformity or signs of injury.

Right lower leg: No edema.

Left lower leg: No edema.

Comments: **Tenderness on palpation of upper, lower back, shoulders, knees, hips, neck**

Skin:

General: Skin is warm and dry.

Neurological:

Mental Status: She is alert and oriented to person, place, and time.

Deep Tendon Reflexes: Reflexes are normal and symmetric.



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 10/2/2019

10/02/2019 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

ASSESSMENT / IMPRESSION:

	ICD-8-CM	ICD-10-CM
1. Rheumatoid arthritis involving both wrists with positive rheumatoid factor (HCC)	714.0	M05.731
		M05.732
2. Enteropathic arthritis	713.1	M07.60
3. Fibromyalgia	729.1	M79.7

Plan

Fibromyalgia in a patient with a hx of enteropathic arthritis:

Pt presented with widespread musculoskeletal pain involving the upper back and spine, neck, shoulders and the lower back and spine (including the buttocks), associated with fatigue and sleep disturbances.

Will start amitriptyline 25 mg QHS, will increase Sulfasalazine to 3 tabs BID

C/w Ustekinumab

Will decrease Methotrexate to 0.5 MI Q7 days for 4 weeks as her enteropathic arthritis is reasonable well controlled

Patient instructions:

Please decrease methotrexate to 0.5 MI for 4 weeks

START taking amitriptyline 25 mg before bedtime

Continue with stelara

Increase sulfasalazine to 3 tabs twice daily

Follow up in 2 months

The above plan and assessment was discussed with Dr. Freeman and agreed upon.

Author: Mariam Avetisova, MD 10/4/2019 10:34

Electronically signed by Avetisova, Mariam, MD at 10/4/2019 10:46 AM

Freeman, James, MD at 10/2/2019 3:40 PM

Author: Freeman, James, MD

Filed: 10/15/2019 10:23 AM

Editor: Freeman, James, MD (Physician)

Service: —

Encounter Date: 10/2/2019

Author Type: Physician

Status: Signed

I saw and evaluated the patient. Discussed with resident and agree with the resident's findings and plan as documented in the resident's note.

James Freeman, MD

Supervising physician

Electronically signed by Freeman, James, MD at 10/15/2019 10:23 AM



GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/13/2019

09/13/2019 - Ocular Visit in Sayre Optometry

Clinic Notes

Progress Notes

Galizia, Frank L, OD at 9/13/2019 1:00 PM

Author: Galizia, Frank L, OD

Service: —

Author Type: Optometrist

Filed: 9/13/2019 1:27 PM

Encounter Date: 9/13/2019

Status: Signed

Editor: Galizia, Frank L, OD (Optometrist)

Patient Name: Jennifer Lyn Brown

MRN: 340616

Date of Birth: 10/26/1976

Assessment:

		ICD-9-CM	ICD-10-CM
1.	Myopia of both eyes	367.1	H52.13
2.	Allergic conjunctivitis of both eyes	372.14	H10.13

Plan

Rx for replacement glasses, optional

Start Zaditor 2-3x/day /PRN

Monitor in one year

Author: Frank L Galizia, OD

Electronically signed by Galizia, Frank L, OD at 9/13/2019 1:27 PM

Ophthalmology

Base Eye Exam

Visual Acuity (Snellen - Linear)

	Right	Left
		964


GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/13/2019

09/13/2019 - Ocular Visit in Sayre Optometry (continued)
Ophthalmology (continued)

Dist co	20/20	20/20
Correction: Glasses		

Tonometry (Non-contact air puff, 1:06 PM)

	Right	Left
Pressure	norm	norm

Pupils

	Right	Left
Pupils	PERRL	PERRL
Dark	5	5

Visual Fields

	Right	Left
	Full	Full

Extraocular Movement

	Right	Left
	Full, Ortho	Full, Ortho

Neuro/Psych

Oriented x3: Yes
Mood/Affect: Normal

Slit Lamp and Fundus Exam
External Exam

	Right	Left
External	Normal	Browe twitch = symptoms

Slit Lamp Exam

	Right	Left
Lids/Lashes	Normal position, Skin, Meibomian Glands and Lashes	Normal position, Skin, Meibomian Glands and Lashes
Conjunctiva/Sclera	trace injection	trace injection
Cornea	dry eye = symptoms	dry eye = symptoms
Anterior Chamber	Clear and deep: Chamber Depth:4	Clear and deep: Chamber Depth:4
Iris	Flat with normal pigmentation	Flat with normal pigmentation
Lens	Clear	Clear
Vitreous	Clear	Clear

Fundus Exam

	Right	Left
Disc	Within normal limits	Within normal limits
C/D Ratio	0.2	0.2
Macula	No hem, edema, pigment or thickening	No hem, edema, pigment or thickening
Vessels	Normal caliber, no distortion or attenuation	Normal caliber, no distortion or attenuation

Refraction
Wearing Rx
965

GUTHRIE^{LSM}

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 9/13/2019

09/13/2019 - Ocular Visit in Sayre Optometry (continued)

Ophthalmology (continued)

	Right	Left
Sphere	-3.00	-3.25
Cylinder	-0.50	Sphere
Axis	180	
Age: 2yrs		
Type: SVL		

Manifest Refraction

	Right	Left
Sphere	-3.00	-3.25
Cylinder	-0.50	-0.25
Axis	180	150

Final Rx

	Right	Left
Sphere	-3.00	-3.25
Cylinder	-0.50	-0.25
Axis	180	150

Expiration Date: 9/13/2020

End of Report

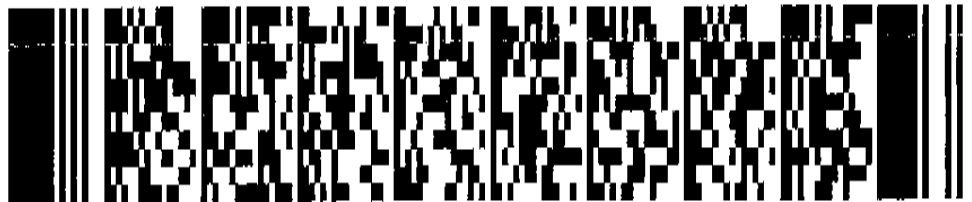
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PAGE: 53 OF 53

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

877-304-5049



RQID:0000000000000000278425518 SITE:X02 DR:S
SSN:132582507 DOCTYPE:5032 RF:D CS:195d

Claimant: Jennifer Brown
SSN: 132-58-2507

*0909CIP A1004488*NOTAF.P.X3.CIPAF.P.ODARS.R200624.PSIK 04001001040000030000C?0011200624365530102728



FOSTER LAW OFFICE

EXHIBIT NO. B13F

PAGE: 1 OF 65

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PRIVILEGED AND CONFIDENTIAL

July 14, 2020

Syracuse, NY OHO
P.O. Box 9045
London, KY 40742-9045

RE: Jennifer Brown
SSN: 132-58-2507

Dear Ladies and Gentlemen:

Enclosed herein please find the following medical records to be included in the above referenced file.

- Guthrie Clinic -- 09/13/2019 through 06/10/2020

Should you have any questions or concerns, please do not hesitate to contact my law office.

Sincerely,
FOSTER LAW OFFICE

JONATHAN P. FOSTER, JR., ESQUIRE

JPF.Jr./jns



GUTHRIE

Brown, Jennifer Lyn

PAGE: 2 OF 65

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/10/2020

06/10/2020 - Office Visit in Sayre Rheumatology

Clinic Notes

Progress Notes

Freeman, James, MD at 6/10/2020 3:00 PM

Author: Freeman, James, MD

Service: —

Author Type: Physician

Filed: 6/26/2020 11:15 AM

Encounter Date: 6/10/2020

Status: Signed

Editor: Freeman, James, MD (Physician)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 6/10/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.

HPI

Follow up for enteropathic arthritis with underlying Crohn's disease. Also with positive RF and fibromyalgia, so her joint symptoms appear to be multi-factorial. She has not heard about approval for high dose xeljanz and remains on bimonthly stelara and sulfasalazine 1.5gm bid. She takes gabapentin 300mg hs and sleeps well. Her colitis symptoms are minimal, but she has the usual aches and pains in her shoulders, hands, hips, knees, ankles. Not a lot of joint swelling. Morning stiffness 15-30 minutes. No symptoms of psoriasis or iritis. She is applying for disability.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/10/2020

EXHIBIT NO. B13F

PAGE: 3 OF 65

06/10/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
<i>Anxiety</i>		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		
• Heart	Father	
<i>?Marfan's Syndrome</i>		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
<i>Aortic Dissection, Marfan's Syndrome</i>		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
<i>ADHD</i>		
• Genetic	Maternal Aunt	
<i>Marfan syndrome</i>		
• Psychiatry	Other	
<i>ADHD</i>		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Current Outpatient Medications

Medication	Site
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.

970



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/10/2020

EXHIBIT NO. B13F

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06/10/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- | | |
|-------------------------------------|--|
| • Blood Glucose Monitor Software | 1 Device by Does not apply route AS DIRECTED. Brand: |
| Does not apply Device | Insurance preferred |
| • buPROPion (WELLBUTRIN XL) | Take 1 Tab by mouth DAILY. |
| 300 MG Oral TABLET SR 24 HR | |
| • calcium carbonate (CALTRATE) | Take 1 Tab by mouth TWICE DAILY. |
| 600 MG Oral Tab | |
| • Cholecalciferol (VITAMIN D3) 25 | Take 1 Cap by mouth DAILY. |
| MCG (1000 UT) Oral Cap | |
| • cyanocobalamin (VITAMIN B12) | INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS |
| 1000 MCG/ML Injection Solution | |
| • cyclobenzaprine (FLEXERIL) 10 | Take 1 Tab by mouth THREE TIMES DAILY AS |
| MG Oral Tab | NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML | 0.3 mg by Injection route AS NEEDED (bee sting). |
| Injection Solution Auto-injector | |
| • fluticasone (FLONASE) 50 | Spray 2 Sprays in nose DAILY. |
| MCG/ACT Nasal Suspension | |
| • foliC acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • gabapentin (NEURONTIN) 100 | Take 3 Caps by mouth EVERY BEDTIME for 60 days. |
| MG Oral Cap | |
| • Glucose Blood (BLOOD | 1 Strip by Apply externally route DAILY AS NEEDED (low |
| GLUCOSE TEST STRIPS) In Vitro | sugar). Insurance preferred |
| Strip | |
| • Glucose Blood In Vitro Strip | 1 Strip by In Vitro route DAILY. One touch verio test |
| | strips |
| • Insulin Syringe-Needle U-100 | 1 Each by Does not apply route EVERY 7 DAYS. |
| (ADVOCATE INSULIN SYRINGE) | |
| 31G X 5/16" 1 ML Does not apply | |
| Misc | |
| • Lancets Does not apply Misc | by Does not apply route DAILY AS NEEDED (low sugar). |
| | Brand: insurance preferred |
| • Levonorg-Eth Estrad Triphasic | Take 1 Tab by mouth DAILY. |
| (TRIVORA, 28,) 50-30/75-40/ 125- | |
| 30 MCG Oral Tab | |
| • lisinopril (PRINIVIL, ZESTRIL) 20 | TAKE 1 TABLET DAILY |
| MG Oral Tab | |
| • loratadine (CLARITIN, ALAVERT) | Take 1 Tab by mouth DAILY. |
| 10 MG Oral Tab | |
| • ondansetron (ZOFTRAN ODT) 8 | Take 1 Tab by mouth EVERY EIGHT HOURS AS |
| MG Oral TABLET DISPERSIBLE | NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG | TAKE 1 TABLET DAILY |
| Oral Tab EC | |
| • Probiotic Product (VSL#3) Oral | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. |
| Cap | May increase to BID pm |
| • sulfasalazine (AZULFIDINE) 500 | Take 3 Tabs by mouth TWICE DAILY. |
| MG Oral Tab | |
| • Syringe/Needle, Disp, 25G X 1- | Inject 1 mL within a muscle EVERY THIRTY DAYS. |
| 1/2" 5 ML Does not apply Misc | Inject 1 mL of Vit B12 IM every 30 days |
| • Tofacitinib Citrate (XELJANZ) 10 | Take 10 mg by mouth TWICE DAILY. |
| MG Oral Tab | |
| • Ustekinumab 90 MG/ML | Inject 90 mg beneath the skin AS DIRECTED. Inject |
| Subcutaneous Solution Prefilled | every 8 weeks. Indications: Crohn's Disease |
| Syringe | |
| • venlafaxine (EFFEXOR XR) 150 | TAKE 1 CAPSULE DAILY |
| MG Oral CAPSULE SR 24 HR | |
| • venlafaxine (EFFEXOR XR) 37.5 | Take 2 Caps by mouth DAILY. |

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/10/2020



06/10/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

MG Oral CAPSULE SR 24 HR

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen

- Bee Stings [Bee Sting]
- Oxycodone
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

Swelling
Hives
Rash
Rash

Social History

Socioeconomic History

- Marital status: Separated
Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
Worry: Not on file
Inability: Not on file
- Transportation needs
Medical: Not on file
Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
Partners: Male
Birth control/protection: Pill, Condom
Comment: OCPs

Lifestyle

- Physical activity
Days per week: Not on file
Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections
Talks on phone: Not on file
Gets together: Not on file
Attends religious service: Not on file
Active member of club or organization: Not on file



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/10/2020

06/10/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

Attends meetings of clubs Not on file
or organizations:

Relationship status: Not on file

• Intimate partner violence

Fear of current or ex Not on file
partner:

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Constitutional: Negative.

HENT: Negative.

Eyes: Negative.

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: Negative.

Skin: Negative.

Neurological: Negative.

Objective

PHYSICAL EXAM:

VITALS: There were no vitals taken for this visit. There is no height or weight on file to calculate BMI.

Physical Exam

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM
1. Enteropathic arthritis	713.1	M07.60
2. Fibromyalgia	729.1	M79.7
3. Crohn's disease of large intestine with other complication (HCC)	555.1	K50.118

Intestinal symptoms are well controlled on stelara, but joint symptoms remain active.

Plan

Start xeljanz 22mg daily.

DC stelara.

Continue other current medications.

RV 3 months

This encounter was done via telemedicine due to the COVID pandemic. Time spent: 16 minutes, half of which involved reviewing records, counseling, coordinating care, and documenting.

Author: James Freeman, MD 6/10/2020 15:44

Electronically signed by Freeman, James, MD at 6/26/2020 11:15 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/10/2020

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06/10/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)


GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/10/2020

EXHIBIT NO. B13F

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06/10/2020 - Lab in Sayre Laboratory

Labs

COMPREHENSIVE METABOLIC PANEL [173964687] (Final result)

Status: Completed

Electronically signed by: Jewell, Jan, RN on 12/03/19 1004

Ordering user: Jewell, Jan, RN 12/03/19 1004

Authorized by: Freeman, James, MD

Cosigning events

Electronically cosigned by Freeman, James, MD 03/29/20 1752 for Ordering

Frequency: Routine 12/03/19 -

Quantity: 1

Instance released by: Northrup, Jon D 6/10/2020 7:42 AM

Diagnoses

High risk medication use [Z79.899]

Ordering provider: Freeman, James, MD

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
GC20-162C0211	Blood	Blood - Veni	Northrup, Jon D 06/10/20 0745

COMPREHENSIVE METABOLIC PANEL [173964687]

Resulted: 06/10/20 0833, Result status: Final result

Ordering provider: Freeman, James, MD 06/10/20 0742

Order status: Completed

Filed by: Interface, Lab Orders 06/10/20 0833

Collected by: Northrup, Jon D 06/10/20 0745

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
Sodium	137	134 - 145 mmol/L	—	GMG
Potassium	4.3	3.5 - 5.1 mmol/L	—	GMG
Chloride	103	98 - 107 mmol/L	—	GMG
CO2	28	22 - 30 mmol/L	—	GMG
Calcium	8.7	8.3 - 10.1 mg/dl	—	GMG
Albumin	4.2	3.5 - 5.0 g/dl	—	GMG
BUN	17	7 - 17 mg/dl	—	GMG
Creatinine	0.8	0.7 - 1.2 mg/dl	—	GMG
Glucose	91	70 - 99 mg/dl	—	GMG
Total Protein	7.2	6.3 - 8.2 g/dl	—	GMG
Total Bilirubin	0.4	0.0 - 1.1 MG/DL	—	GMG
AST	24	15 - 46 U/L	—	GMG
ALT	23	9 - 52 U/L	—	GMG
Alkaline Phosphatase	49	40 - 150 U/L	—	GMG
eGFR	>60	See Interpretation	—	GMG
		Below		
		ml/min/1.73m ² Sq		

Comment:

Estimated GFR Interpretation:

Above 60ml/min/1.73m² = Normal Renal Function30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease15-29 ml/min/1.73m² = Stage 4 Chronic Kidney DiseaseLess than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease

The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:

<https://www.kidney.org/content/mdrd-study-equation>

BUN/Creatinine Ratio	21	6 - 22 RATIO	—	GMG
Anion Gap	6	3 - 11 mmol/L	—	GMG
A/G Ratio	1.4	0.8 - 2.0 ratio	—	GMG

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG		GUTHRIE MEDICAL GROUP	Hojati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

975



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/10/2020

EXHIBIT NO. B13F

PAGE: 9 OF 65

06/10/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

LABORATORY

Indications

High risk medication use [Z79.899 (ICD-10-CM)]

CBC WITH DIFFERENTIAL [173964688] (Final result)

Status: Completed

Electronically signed by: Jewell, Jan, RN on 12/03/19 1004

Ordering user: Jewell, Jan, RN 12/03/19 1004

Ordering provider: Freeman, James, MD

Authorized by: Freeman, James, MD

Ordering mode: Standard

Cosigning events

Electronically cosigned by Freeman, James, MD 03/29/20 1752 for Ordering

Frequency: Routine 12/03/19 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Northrup, Jon D 6/10/2020 7:42 AM

Diagnoses

High risk medication use [Z79.899]

Specimen Information

ID	Type	Source	Collected By
GC20-162H0190	Blood	Blood - Veni	Northrup, Jon D 06/10/20 0745

CBC WITH DIFFERENTIAL [173964688] (Abnormal)

Resulted: 06/10/20 0805, Result status: Final result

Ordering provider: Freeman, James, MD 06/10/20 0742

Order status: Completed

Filed by: Interface, Lab Orders 06/10/20 0805

Collected by: Northrup, Jon D 06/10/20 0745

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
WBC Count	10.75	3.98 - 10.04 K/uL	H ^	GMG
RBC Count	4.66	3.93 - 5.22 M/uL	—	GMG
Hemoglobin	13.1	11.2 - 15.7 g/dL	—	GMG
Hematocrit	41.4	34.1 - 44.9 %	—	GMG
MCV	88.8	79.4 - 94.8 fL	—	GMG
MCH	28.1	25.6 - 32.2 pg	—	GMG
MCHC	31.6	32.2 - 35.5 g/dL	L v	GMG
Platelet Count	311	182 - 369 K/uL	—	GMG
MPV	9.5	9.4 - 12.3 fL	—	GMG
RDW	13.4	11.7 - 14.4 %	—	GMG
Neutrophil %	57.0	34.0 - 71.1 %	—	GMG
Lymphocyte %	30.4	19.3 - 51.7 %	—	GMG
Monocyte %	9.7	4.7 - 12.5 %	—	GMG
Eosinophil %	1.7	0.7 - 5.8 %	—	GMG
Basophil %	0.5	0.1 - 1.2 %	—	GMG
nRBC %	0.0	0.0 - 0.2 %	—	GMG
Neutrophil #	6.14	1.56 - 6.13 K/uL	H ^	GMG
Lymphocyte #	3.27	1.18 - 3.74 K/uL	—	GMG
Monocyte #	1.04	0.24 - 0.86 K/uL	H ^	GMG
Eosinophil #	0.18	0.04 - 0.36 K/uL	—	GMG
Basophil #	0.05	0.01 - 0.08 K/uL	—	GMG
Immature Gran %	0.7	0.0 - 0.4 %	H ^	GMG
Immature Gran #	0.07	0.00 - 0.03 K/uL	H ^	GMG
NRBC #	0.00	0.00 - 0.12 K/uL	—	GMG

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/10/2020

**06/10/2020 - Lab in Sayre Laboratory (continued)****Labs (continued)**

6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present
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Indications

High risk medication use [Z79.899 (ICD-10-CM)]



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/3/2020

06/03/2020 - Office Visit in Sayre Orthopedics

Clinic Notes

Progress Notes

March, Melanie E, FNP-C at 6/3/2020 9:00 AM

Author: March, Melanie E, FNP-C

Service: —

Author Type: Nurse Practitioner

Filed: 6/5/2020 11:22 AM

Encounter Date: 6/3/2020

Status: Signed

Editor: March, Melanie E, FNP-C (Nurse Practitioner)

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 6/3/2020

Chief Complaint

Patient presents with

- Knee Pain

Left knee epain.

The patient is here at the request of the the patient's provider for evaluation of a painful left knee.

HPI: Jennifer Lyn Brown is a 43-y.o. female who presents to the clinic today complaining of pain in the left knee. According to the patient it began several months ago. Patient saw PCP in February/March and had US which showed fluid on the knee, according to the patient. Her PCP ordered PT and patient got to attend 1 time due to COVID. Patient then had a fall and has had increase in symptoms in the left knee since. The patient indicates the location of pain as the medial knee. The patient characterizes the pain as being aching. Patient states the pain began several months ago and is intermittent. Exacerbating factors include squatting, kneeling, pivoting, alleviating factors include rest and over the counter NSAID's. Treatments to date have included rest and over the counter NSAID's. Patient reports associated catching and giving out swelling. Patient denies grinding lower leg pain, numbness, tingling fevers, chills, night sweats, constitutional symptoms.

Past Medical Hx: has a past medical history of Anal fissure (1/2013), Anxiety, Attention deficit, Back ache (3/18/2014), Calcaneal spur (6/30/2008), Cherry angioma (8/9/2016), Cholecystitis, CHRONIC SINUSITIS NOS (5/23/2005), Crohn disease (HCC), Depression (1/20/2014), Endocrine problem, Epicondylitis elbow, medial (10/7/2008), Fatty liver, Fibromyalgia (8/20/2014), Fractures, Gastroparesis, GERD (gastroesophageal reflux disease) (10/7/2008), HTN (hypertension), benign (10/7/2008), Hypertension, Morbidly obese (HCC), Multinodular goiter, Nontoxic multinodular goiter (1/18/2011), Obesity, Persistent mental disorders due to conditions classified elsewhere, Physiological ovarian cysts (10/7/2008), PLANTAR FIBROMATOSIS (9/9/2004), Premenopausal patient, Rheumatoid arthritis (714.0) (12/12/2008), Severe obstructive sleep apnea (6/10/2013), Sleep apnea, Thyroid nodule (6/3/2010), and Wrist fracture. She also has no past medical history of Abnormal mammogram, unspecified, Actinic keratosis of multiple sites of head and neck, Amenorrhea, Anemia, Anemia of other chronic disease, Anemia, unspecified, Asthma, Awareness under anesthesia, Bladder disease, Blood transfusion, Blood transfusion without reported diagnosis, Bone loss, BRCA1 positive, BRCA2 positive, Breast cancer (HCC), Breast injury, Breast mass, Cancer (HCC), Cancer, colon (HCC), Cerebral thrombosis without mention of cerebral infarction, Chronic airway obstruction, not elsewhere classified, Chronic kidney disease, Clostridium difficile infection, Clotting disorder (HCC), Colitis, Colon polyp, Diabetes mellitus, Diabetes mellitus (HCC), Difficult menstruation, Diverticulitis, Duodenitis, Duodenitis, Dysmenorrhea, Dyspareunia, Embolism and thrombosis of unspecified site, Endometriosis, Endometriosis, Eye disease, Eye injuries, Female infertility of unspecified origin, Fibroid, Gastritis, Generalized convulsive epilepsy, Genital wart, Heart disease, unspecified, Heart murmur, Hemorrhoid, Hernia of unspecified site of abdominal cavity without mention of obstruction or gangrene

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/3/2020

06/03/2020 Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

History of breast surgery, History of chemotherapy, History of mastectomy, HIV infection (HCC), Hormonal contraceptive, Hormone disorder, Hormones and synthetic substitutes causing adverse effect in therapeutic use, Hyperthermia, malignant, Infection with microorganisms resistant to penicillins, Infertility, female, Intermediate coronary syndrome (HCC), Inversion, nipple, congenital, Irregular uterine bleeding, Irritable bowel syndrome, Irritable bowel syndrome (IBS), Kidney stone, Lazy eye, Left heart failure (HCC), Lipidoses, Liver cancer (HCC), Localized adhesions and strands of conjunctiva, Lymphoma (HCC), Malignant hyperthermia, Malignant hyperthermia due to anesthesia, Malignant neoplasm of colon, Malignant neoplasm of esophagus (HCC), Malignant neoplasm of liver, primary (HCC), Melanoma (HCC), NERVE, Nipple discharge, Nulliparity, Obstruction colon, Osteoarthritis and allied disorders, Osteoporosis, Other disorders of breast, Other malignant neoplasm without specification of site, Ovarian cancer (HCC), Pain on intercourse, Pancreatitis, Peripheral vascular disease, unspecified (HCC), PID (pelvic inflammatory disease), Poisoning, glutethimide group, PONV (postoperative nausea and vomiting), Postmenopausal, Pregnancy, first, Primary tuberculous complex, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically, Prostate disease, Pseudocholinesterase deficiency, Psoriasis, Rectal cancer (HCC), Skin cancer, Skin cancer, Squamous cell carcinoma, STD (sexually transmitted disease), Stomach cancer (HCC), Substance abuse (HCC), Surgery, elective, Ulcer disease, Ulcer disease, Unspecified disorder of kidney and ureter, Unspecified malignant neoplasm of skin, site unspecified, Urinary bladder incontinence, Urinary incontinence, UTI (urinary tract infection), Viral hepatitis, or Warts, genital.

PAST SURGICAL HISTORY: has a past surgical history that includes tonsillectomy (11/26/07); egd (2002); egd (guthrie / non guthrie); laparoscopic cholecystectomy (2013); egd (N/A, 8/13/2014); pr lap, gast restrict proc, longitudinal gastrectomy (12/10/2014); pr removal gallbladder; pr closed rx tarsal fx, each; colonoscopy (N/A, 6/24/2016); egd (N/A, 6/24/2016); colonoscopy diagnostic; colonoscopy (N/A, 6/2/2017); egd (N/A, 6/2/2017); colonoscopy (N/A, 6/11/2018); egd (N/A, 6/11/2018); pr shldr arthroscop, part acromioplasm (Left, 5/24/2019); colonoscopy (N/A, 1/29/2020); and egd (N/A, 1/29/2020).

MEDICATIONS:**Current Outpatient Medications:**

- ALPRAZolam (XANAX) 0.25 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg., Disp: 15 Tab, Rfl: 0
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab, Take 1 Tab by mouth EVERY BEDTIME., Disp: 90 Tab, Rfl: 0
- Blood Glucose Monitor Software Does not apply Device, 1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred, Disp: 1 Device, Rfl: 0
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS, Disp: 10 mL, Rfl: 3
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/3/2020

06/03/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

Rfl: 0

- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- gabapentin (NEURONTIN) 100 MG Oral Cap, Take 3 Caps by mouth EVERY BEDTIME for 60 days., Disp: 90 Cap, Rfl: 1
- Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip, 1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred, Disp: 90 Strip, Rfl: 1
- Glucose Blood In Vitro Strip, 1 Strip by In Vitro route DAILY. One touch verio test strips, Disp: 100 Strip, Rfl: 1
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc, 1 Each by Does not apply route EVERY 7 DAYS., Disp: 100 Each, Rfl: 0
- Lancets Does not apply Misc, by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred, Disp: 90 Each, Rfl: 1
- Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 28 Tab, Rfl: 0
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab, Take 3 Tabs by mouth TWICE DAILY., Disp: 120 Tab, Rfl: 2
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab, Take 10 mg by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 1
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease, Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, TAKE 1 CAPSULE DAILY, Disp: 90 Cap, Rfl: 3
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR, Take 2 Caps by mouth DAILY., Disp: 180 Cap, Rfl: 1

Current Facility-Administered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

ALLERGIES: is allergic to bee stings [bee sting]; oxycodone; remicade [infliximab]; and tape: silk or adhesive.

SOCIAL HISTORY: reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

FAMILYHISTORY: family history includes Arthritis in her mother; Cancer in her paternal grandfather; Clotting Disorder in her father; Diabetes in her father, maternal grandfather, and mother; Genetic in her father and maternal aunt; Heart in her father, mother, and paternal uncle; Heart Disease in her father, mother, and paternal uncle; Hypertension in her father and mother; Kidney Disease in her mother; Macular Degeneration in her paternal grandmother; Psychiatry in her maternal aunt, mother, and other; Thyroid Disease in her



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/3/2020

06/03/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

maternal grandfather.

ROS: See HPI otherwise all other ROS are negative at this time

Exam:

General Appearance: Patient is a well developed, well nourished Caucasian female in no acute distress. Alert and oriented times three.

Vitals: Resp 20 | Ht 5' 11" (1.803 m) | Wt 290 lb (131.5 kg) | BMI 40.45 kg/m² Body mass index is 40.45 kg/m².

Gait: Patient walks with unassisted, normal gait.

Integumentary: Skin overlying the knee is healthy without any erythema, ecchymosis, masses, rashes, or lesions.

Knee: There is no obvious clinical deformity. Range of motion of the left knee demonstrates extension 0, flexion 130. There is not crepitus throughout range of motion. There is not pain at extremes of motion. Patient has tenderness over the medial joint line, tenderness over medial collateral ligament. Ligamentous stress testing reveals negative Anterior drawer, Posterior drawer, Varus instability, Valgus instability. McMurray's test is Positive. Patellar testing reveals negative compression, apprehension.

Muscular: Knee extension strength is 5 out of 5, knee flexion strength is 5 out of 5, plantar flexion strength is 5 out of 5, dorsiflexion strength is 5 out of 5.

Neurological: Sensation is intact to the medial, lateral, dorsal, and plantar, aspects of the foot.

Vascular: Pedal pulse is present. Pedal edema is absent. Skin condition to the foot is unremarkable and intact.

Imaging: x-rays obtained today of the left knee demonstrate

IMPRESSION

No acute findings.

X-rays reviewed by myself and with patient.

Impression:

	ICD-9-CM	ICD-10-CM	
1. Left medial knee pain	719.46	M25.562	REFER TO ORTHOPEDICS REFER TO PHYSICAL THERAPY / REHAB INJECTION, JOINT SHOUDLER HIP KNEE OR BURSA methyIPREDNISolone acetate (DEPO-MEDROL) injection 80 MG/ML

**GUTHRIE**

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/3/2020

PAGE: 15 OF 65**06/03/2020 - Office Visit in Sayre Orthopedics (continued)****Clinic Notes (continued)**

2. Effusion of left knee 719.06 M25.462 REFER TO ORTHOPEDICS

Plan:

The patient was advised of the above diagnosis including the pathology, prognosis, and further treatment options. Options for non-surgical management included continued activity modification, intermittent use of NSAIDs, therapeutic exercises, walking aids, physical therapy. More invasive management with a differential injection was also discussed. Further diagnostic imaging with MRI was discussed. Surgical management with knee arthroscopy and total knee arthroplasty was discussed including the procedure, pre and post-operative course, and material risks and benefits.

At this time she has elected to proceed with continue current treatment, physical therapy, cortisone injection(s). Her questions and concerns were addressed and answered to her satisfaction.

The patient was educated on the risks and benefits of an injection. She understands and they wish to proceed. Therefore, under sterile conditions, the patient's left knee was injected with 9 cc of lidocaine and 80 mg of Depo-Medrol. The patient tolerated the procedure well, had no adverse effects following the injection. They will ice the affected area tonight, and they will call me back if there is any adverse reaction.

She will follow up in 4 weeks or sooner if necessary.

Author: Melanie E March, FNP-C 10:08. 6/3/2020

Electronically signed by March, Melanie E, FNP-C at 6/5/2020 11:22 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

EXHIBIT NO. B13F

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06/02/2020 - Office Visit in Guthrie Endocrinology-Desmond

Clinic Notes

Progress Notes

Piatok, David, MD at 6/2/2020 1:20 PM

Author: Piatok, David, MD
Filed: 6/2/2020 7:01 PM
Editor: Piatok, David, MD (Physician)

Service: ---
Encounter Date: 6/2/2020

Author Type: Physician
Status: Signed

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 6/2/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- New Patient
hypoglycemia

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.

HPI

She is referred by PCP for symptoms suggestive of hypoglycemia. Her last visit here in Guthrie Endocrinology was with Dr. Keri Kissel a couple of years ago for her nontoxic multinodular goiter in which US-guided FNA biopsy showed benign thyroid nodule. Today she is here for management of symptoms suggestive of hypoglycemia. Patient describes a feeling of shakiness or lightheadedness which can be in the morning or afternoon. She tells of sometimes experiencing "brain fog."

Biochemical work-up ordered by PCP showed January 22, 2020 lab work revealing normal vitamin D and TSH levels, A1c of 5.1 normal beta hydroxybutyrate and normal pro insulin level. Her glucose on that day was normal at 87. C-peptide was upper end of normal coming in at 3.18. But insulin was high at 20.1. A CMP was done 3-11-2020 which came back normal.

PMH for the patient includes gastric sleeve surgery in 2014, sleep apnea for which she faithfully uses her CPAP every night, obesity, NAFLD, rheumatoid arthritis and Crohn disease. Takes Azulfidine and Stelara for her rheumatologic disorders. Has used prednisone in the past but has not had any since 2019. Also happens to have NAFLD.

Is accompanied to today's visit by her boyfriend, Jonathan.

Past Medical History:

Diagnosis	Date
Anal fissure	1/2013
Anxiety	
Attention deficit	
Back ache	3/18/2014
Calcaneal spur	6/30/2008
Cherry angioma	8/9/2016
Cholecystitis	
CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
Crohn disease (HCC)	
Depression	1/20/2014
Endocrine problem	
Epicondylitis elbow, medial	10/7/2008
Fatty liver	
Fibromyalgia	8/20/2014

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 - Office Visit in Guthrie Endocrinology-Desmond (continued)

Clinic Notes (continued)

- Fractures
- Gastroparesis
- irritable bowel syndrome
- GERD (gastroesophageal reflux disease) 10/7/2008
- HTN (hypertension), benign 10/7/2008
- Hypertension
- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
<i>Anxiety</i>		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		
• Heart	Father	
<i>?Marfan's Syndrome</i>		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
<i>Aortic Dissection, Marfan's Syndrome</i>		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
<i>ADHD</i>		
• Genetic	Maternal Aunt	
<i>Marfan syndrome</i>		
• Psychiatry	Other	
<i>ADHD</i>		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 - Office Visit in Guthrie Endocrinology - Desmond (continued)

Clinic Notes (continued)

- | | |
|----------------------|-------------------|
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• Blood Glucose Monitor Software Does not apply Device	1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• gabapentin (NEURONTIN) 100 MG Oral Cap	Take 3 Caps by mouth EVERY BEDTIME for 60 days.
• Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip	1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred
• Glucose Blood In Vitro Strip	1 Strip by In Vitro route DAILY. One touch verio test strips
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• Lancets Does not apply Misc	by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred
• Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	TAKE 1 TABLET DAILY
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	TAKE 1 TABLET DAILY
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
• sulfasalazine (AZULFIDINE) 500	Take 3 Tabs by mouth TWICE DAILY.



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 - Office Visit in Guthrie Endocrinology-Desmond (continued)

Clinic Notes (continued)

MG Oral Tab	
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS.
• Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab	Inject 1 mL of Vit B12 IM every 30 days
• Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Take 10 mg by mouth TWICE DAILY.
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
• venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR	TAKE 1 CAPSULE DAILY
	Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
 - Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

GUTHRIESM

Brown, Jennifer Lyn

PAGE: 20 OF 65

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/2/2020

06/02/2020 Office Visit in Guthrie Endocrinology-Desmond (continued)

Clinic Notes (continued)

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections
 - Talks on phone: Not on file
 - Gets together: Not on file
 - Attends religious service: Not on file
 - Active member of club or organization: Not on file
 - Attends meetings of clubs or organizations: Not on file
 - Relationship status: Not on file
- Intimate partner violence
 - Fear of current or ex partner: Not on file
 - Emotionally abused: Not on file
 - Physically abused: Not on file
 - Forced sexual activity: Not on file

Other Topics

Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

Review of Systems

Endo/Heme/Allergies:

ROS for symptoms suggestive of hypoglycemia can be found in the HPI.

Objective

PHYSICAL EXAM:

VITALS: BP 124/80 (BP Location: Left arm, Patient Position: Sitting) | Pulse 77 | Wt 290 lb (131.5 kg) | BMI 40.45 kg/m² Body mass index is 40.45 kg/m².

Physical Exam

Constitutional:

Comments: Demonstrating normal behavior and intact cognition.

Skin:

Comments: No pallor, jaundice, erythema, or bruising, on the exposed skin areas.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. Hypoglycemia	251.2	E16.2	REFER TO ENDOCRINOLOGY

Patient has already been given a glucose meter by PCP.

I instructed the patient to test fasting and 2 hours postprandially a few days of the week.

She will also test when she is experiencing the symptoms suggestive of hypoglycemia.

Patient Instructions

**GUTHRIE**

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/2/2020

EXHIBIT NO. B13F**PAGE: 21 OF 65****06/02/2020 - Office Visit in Guthrie Endocrinology-Desmond (continued)****Clinic Notes (continued)**

Test your blood glucose levels at wake-up time and 2 hours after the end of the meal, M-W-Sat.

Please write down all of the results in your log sheet.

Bring your log sheet to our next visit. Also, bring your True Metrix Meter.

Follow-up here in Endocrinology in 1 month.

Plan**Patient Instructions**

Test your blood glucose levels at wake-up time and 2 hours after the end of the meal, M-W-Sat.

Please write down all of the results in your log sheet.

Bring your log sheet to our next visit. Also, bring your True Metrix Meter.

Follow-up here in Endocrinology in 1 month.

The amount of time spent in face-to-face visit with the patient was 45 minutes. The portion of this time devoted to counseling, coordination of care, & medical decision making, was 70%.

Author: David Piatok, MD 6/2/2020 18:44

Electronically signed by Piatok, David, MD at 6/2/2020 7:01 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 Office Visit in Sayre Orthopedics

Clinic Notes

Progress Notes

March, Melanie E, FNP-C at 6/2/2020 11:00 AM

Author: March, Melanie E, FNP-C

Service: —

Author Type: Nurse Practitioner

Filed: 6/5/2020 12:17 PM

Encounter Date: 6/2/2020

Status: Signed

Editor: March, Melanie E, FNP-C (Nurse Practitioner)

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 6/2/2020

Chief Complaint

Patient presents with

- New Patient

pain for a few months, NKL. Sharp pains. Worse at night. Pain lifting arm above head, behind back, lifting objects. Occasionally radiates to the elbow

- Shoulder Pain

Right

The patient is here at the request of the the patient's provider for evaluation of a painful right shoulder.

HPI: Jennifer Lyn Brown is a 43-y.o. female who presents to the clinic today complaining of pain in the right shoulder. According to the patient it began several months ago with no known injury. The patient characterizes the pain as being sharp. Patient rates the pain as a 7/10 with activity and grades pain as a 2/10 at rest. Noted the pain at the medial and posterior aspects of the shoulder. Patient states the pain is gradually worsening. Pain causes trouble with performing ADLs and quality of sleep. Exacerbating factors include lateral movements, sleeping, alleviating factors include heat, rest, acetaminophen and over the counter NSAID's. Treatments to date have included heat, ice, rest, acetaminophen and over the counter NSAID's. Patient reports associated popping. Patient denies locking and grinding swelling, previous injury fevers, chills, night sweats, constitutional symptoms. According to the patient she has a history of problems with left shoulder and had shoulder arthroscopy by Dr. Choi.

Past Medical Hx: has a past medical history of Anal fissure (1/2013), Anxiety, Attention deficit, Back ache (3/18/2014), Calcaneal spur (6/30/2008), Cherry angioma (8/9/2016), Cholecystitis, CHRONIC SINUSITIS NOS (5/23/2005), Crohn disease (HCC), Depression (1/20/2014), Endocrine problem, Epicondylitis elbow, medial (10/7/2008), Fatty liver, Fibromyalgia (8/20/2014), Fractures, Gastroparesis, GERD (gastroesophageal reflux disease) (10/7/2008), HTN (hypertension), benign (10/7/2008), Hypertension, Morbidly obese (HCC), Multinodular goiter, Nontoxic multinodular goiter (1/18/2011), Obesity, Persistent mental disorders due to conditions classified elsewhere, Physiological ovarian cysts (10/7/2008), PLANTAR FIBROMATOSIS (9/9/2004), Premenopausal patient, Rheumatoid arthritis(714.0) (12/12/2008), Severe obstructive sleep apnea (6/10/2013), Sleep apnea, Thyroid nodule (6/3/2010), and Wrist fracture.

PAST SURGICAL HISTORY: has a past surgical history that includes tonsillectomy (11/26/07); egd (2002); egd (guthrie / non guthrie); laparoscopic cholecystectomy (2013); egd (N/A, 8/13/2014); pr lap, gast restrict proc, longitudinal gastrectomy (12/10/2014); pr removal gallbladder; pr closed rx tarsal fx, each; colonoscopy (N/A, 6/24/2016); egd (N/A, 6/24/2016); colonoscopy diagnostic; colonoscopy (N/A, 6/2/2017); egd (N/A, 6/2/2017); colonoscopy (N/A, 6/11/2018); egd (N/A, 6/11/2018); pr shldr arthroscop, part acromioplasm (Left, 5/24/2019); colonoscopy (N/A, 1/29/2020); and egd (N/A, 1/29/2020).



Brown, Jennifer Lyn

PAGE: 23 OF 65

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/2/2020

06/02/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

MEDICATIONS:

Current Outpatient Medications:

- ALPRAZolam (XANAX) 0.25 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg., Disp: 15 Tab, Rfl: 0
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab, Take 1 Tab by mouth EVERY BEDTIME., Disp: 90 Tab, Rfl: 0
- Blood Glucose Monitor Software Does not apply Device, 1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred, Disp: 1 Device, Rfl: 0
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution, INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS, Disp: 10 mL, Rfl: 3
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- gabapentin (NEURONTIN) 100 MG Oral Cap, Take 3 Caps by mouth EVERY BEDTIME for 60 days., Disp: 90 Cap, Rfl: 1
- Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip, 1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred, Disp: 90 Strip, Rfl: 1
- Glucose Blood In Vitro Strip, 1 Strip by In Vitro route DAILY. One touch verio test strips, Disp: 100 Strip, Rfl: 1
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc, 1 Each by Does not apply route EVERY 7 DAYS., Disp: 100 Each, Rfl: 0
- Lancets Does not apply Misc, by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred, Disp: 90 Each, Rfl: 1
- Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 28 Tab, Rfl: 0
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn, Disp: 60 Cap, Rfl: 3
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab, Take 3 Tabs by mouth TWICE DAILY., Disp: 120 Tab, Rfl: 2
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab, Take 10 mg by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 1

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease, Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, TAKE 1 CAPSULE DAILY, Disp: 90 Cap, Rfl: 3
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR, Take 2 Caps by mouth DAILY., Disp: 180 Cap, Rfl: 1

Current Facility-Administered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

ALLERGIES: is allergic to bee stings [bee sting]; oxycodone; remicade [infliximab]; and tape: silk or adhesive.

SOCIAL HISTORY: reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

FAMILY HISTORY: family history includes Arthritis in her mother; Cancer in her paternal grandfather; Clotting Disorder in her father; Diabetes in her father, maternal grandfather, and mother; Genetic in her father and maternal aunt; Heart in her father, mother, and paternal uncle; Heart Disease in her father, mother, and paternal uncle; Hypertension in her father and mother; Kidney Disease in her mother; Macular Degeneration in her paternal grandmother; Psychiatry in her maternal aunt, mother, and other; Thyroid Disease in her maternal grandfather.

ROS: See HPI otherwise all other ROS are negative at this time

Exam:

General Appearance: Patient is a well developed, well nourished Caucasian female in no acute distress. Alert and oriented times three.

Vitals: Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².

Neck: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. No bony or soft tissue tenderness. Unrestricted range of motion without pain or reproduction of pain.

Upper back: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. No pain to any bony or soft tissue aspect of the upper back:

Right Shoulder: skin is pink, warm and dry without erythema, ecchymosis, or edema. There are no masses, rashes, or lesions. There are no gross bony abnormalities, malrotations, angulations. There is no clinical deformity of the Right shoulder. She has tenderness about the subacromial space and AC joint. There is no other bony or soft tissue tenderness about the shoulder. There is not crepitus with range of motion. There is not scapulothoracic pain or dyskinesia. The shoulder is stable. Muscle compartments soft. Intact motor and sensory function of the axillary, musculocutaneous, radial, ulnar, and median nerves. Radial and ulna pulses are present.

Right Shoulder Exam



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 6/2/2020

EXHIBIT NO. B13F

PAGE: 25 OF 65

06/02/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

Tenderness

The patient is experiencing tenderness in the acromioclavicular joint and biceps tendon.

Range of Motion

Active abduction: normal

Passive abduction: normal

Extension: 30 abnormal

External rotation: normal

Forward flexion: normal

Muscle Strength

The patient has normal right shoulder strength.

Tests

Impingement: positive

Drop arm: negative

Other

Erythema: absent

Scars: absent

Sensation: normal

Pulse: present

Imaging: x-rays obtained today of the right shoulder demonstrate no abnormality.

Observations:

AP (internal and external rotation) and 45/45 degree views of the right shoulder were obtained. The medial portions of the clavicle and scapula are excluded. There is no evidence of acute fracture or dislocation. The glenohumeral and acromioclavicular joint spaces are maintained. No concerning focal osseous lesions are seen. There is a calcified granuloma in the right upper lung zone. The surrounding soft tissue structures and visualized right upper lung field are otherwise unremarkable.

IMPRESSION

No acute osseous or joint space abnormality of the right shoulder.

X-rays reviewed by myself and with patient.

Impression:

	ICD-9-CM	ICD-10-CM	
1. Acute pain of right shoulder	719.41	M25.511	REFER TO ORTHOPEDICS REFER TO PHYSICAL THERAPY / REHAB INJECTION, JOINT SHOUDLER HIP KNEE OR BURSA methyIPREDNISolone acetate

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 6/2/2020

06/02/2020 - Office Visit in Sayre Orthopedics (continued)

Clinic Notes (continued)

- | | | | |
|----|---|---------------|--|
| 2. | Disorder of bursae and tendons in right shoulder region | 726.10 M75.51 | <p>(DEPO-MEDROL) injection 80 MG/ML</p> <p>REFER TO PHYSICAL THERAPY / REHAB</p> <p>INJECTION, JOINT SHOUDLER</p> <p>HIP KNEE OR BURSA</p> <p>methyIPREDNISolone acetate</p> <p>(DEPO-MEDROL) injection 80 MG/ML</p> |
|----|---|---------------|--|

Plan:

The patient was advised of the above diagnosis including the pathology, prognosis, and further treatment options. Options for non-surgical management included continued activity modification, intermittent use of NSAIDs, therapeutic exercises, occupational therapy and/or physical therapy. More invasive management with a differential injection was also discussed. Further diagnostic imaging with MRI was discussed.

At this time she has elected to proceed with continue current treatment, physical therapy, cortisone injection(s). Her questions and concerns were addressed and answered to her satisfaction.

Using usual sterile technique he was administered a posterior subacromial injection in the right shoulder with 80 mg DepoMedrol and 8 cc 1% plain lidocaine. She tolerated the procedure well without complications. She was instructed to use ice and tylenol for any post injections discomfort. She was evaluated a few minutes after the injection and did have some improvement in range of motion and decrease in pain

She will follow up in 4 weeks or sooner if necessary.

Author: Melanie E March, FNP-C 13:50. 6/2/2020

Electronically signed by March, Melanie E, FNP-C at 6/5/2020 12:17 PM

GUTHRIESM

Brown, Jennifer Lyn

PAGE: 27 OF 65

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 5/26/2020

05/26/2020 Office Visit in Sayre Family Practice

Clinic Notes

Progress Notes

Attia, Maximos, MD at 5/26/2020 10:30 AM

Author: Attia, Maximos, MD

Service: —

Author Type: Physician

Filed: 5/26/2020 11:00 AM

Encounter Date: 5/26/2020

Status: Signed

Editor: Attia, Maximos, MD (Physician)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 5/26/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Injection

Trigger point injection in neck.

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.

HPI

The history is provided by the patient. This is a recurrent problem. The current episode started several years ago (since 1998). The problem occurs intermittently. The problem has been waxing and waning. The pain is associated with falling. There has been no fever. The pain is present in the occipital region and both sides of the neck. The quality of the pain is described as stabbing and burning. The pain is at a severity of 5/10. The pain is moderate. The symptoms are aggravated by bending. She has tried heat for the symptoms. The pain does not radiate.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS CT 2005	5/23/2005
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
• irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	

Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 5/26/2020



05/26/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
ADHD		
• Genetic	Maternal Aunt	
Marfan syndrome		
• Psychiatry	Other	
ADHD		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Current Outpatient Medications

Medications	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 5/26/2020

05/26/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- | | |
|--|---|
| | mg. |
| • amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab | Take 1 Tab by mouth EVERY BEDTIME. |
| • Blood Glucose Monitor Software | 1 Device by Does not apply route AS DIRECTED. Brand: |
| Does not apply Device | Insurance preferred |
| • buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE) 600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution | INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS |
| • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. |
| • folic acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • gabapentin (NEURONTIN) 100 MG Oral Cap | Take 3 Caps by mouth EVERY BEDTIME for 60 days. |
| • Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip | 1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred |
| • Glucose Blood In Vitro Strip | 1 Strip by In Vitro route DAILY. One touch verio test strips |
| • Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc | 1 Each by Does not apply route EVERY 7 DAYS. |
| • Lancets Does not apply Misc | by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred |
| • Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab | Take 1 Tab by mouth DAILY. |
| • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab | TAKE 1 TABLET DAILY |
| • loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab | Take 1 Tab by mouth DAILY. |
| • ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE | Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG Oral Tab EC | TAKE 1 TABLET DAILY |
| • Probiotic Product (VSL#3) Oral Cap | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn |
| • sulfasalazine (AZULFIDINE) 500 MG Oral Tab | Take 3 Tabs by mouth TWICE DAILY. |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days |
| • Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab | Take 10 mg by mouth TWICE DAILY. |
| • Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe | Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease |



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 5/26/2020

05/26/2020 - Office Visit in Sayre Family Practice (continued)**Clinic Notes (continued)**

- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE 1 CAPSULE DAILY
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications**Medication**

- saline (OCEAN) nasal spray 0.65 %

Allergies**Allergen**

- Bee Stings [Bee Sting]
- Oxycodone
- Remicade [Infliximab]
- Tape: Silk Or Adhesive

Reactions

- Swelling
- Hives
- Rash
- Rash

Social History**Socioeconomic History**

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections
 - Talks on phone: Not on file
 - Gets together: Not on file

GUTHRIESM

Brown, Jennifer Lyn

PAGE: 31 OF 65

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 5/26/2020

05/26/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Attends religious service: Not on file
 Active member of club or organization: Not on file
 Attends meetings of clubs or organizations: Not on file
 Relationship status: Not on file
 • Intimate partner violence
 Fear of current or ex partner: Not on file
 Emotionally abused: Not on file
 Physically abused: Not on file
 Forced sexual activity: Not on file

Other Topics Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

ROS

Constitutional: Negative for chills and fever.

Skin: Negative for itching and rash.

Objective

PHYSICAL EXAM:

VITALS: BP (l) 150/110 | Pulse 86 | Temp 98.7 °F (37.1 °C) (Tympanic) | Resp 16 | Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | SpO2 97% | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².

Physical Exam

Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress. No distress.

HEENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Eyes: Conjunctivae are normal. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal. No respiratory distress.

Musculoskeletal: She exhibits tenderness. She exhibits no edema.

Tender spots over left side of neck.

Neurological: She is alert and oriented to person, place, and time.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: Affect and judgment normal.

Vitals reviewed.

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. Muscle pain, cervical	723.1	M54.2	INJECTION TRIGGER POINTS 3 OR



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
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EXHIBIT NO. B13F

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05/26/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

MORE MUSCLES

Trigger point injection procedure note :

The procedure risks, hazards and alternatives were discussed with the patient and a consent was obtained. The area over the myofascial spasm were prepped with alcohol utilizing sterile technique. After isolating it between two palpating fingertips a 25-gauge needle was placed in the center of the myofascial spasms and a negative aspiration was performed. Then a total of 10 cc of Lidocaine 1% was injected into the trigger points. The patient tolerated the procedure well without any apparent difficulties or complications. Patient was feeling relief by the time the block had set.

Injection was made on the both sides of neck.

Plan

Author: Maximos Attia, MD 5/26/2020 11:00

Electronically signed by Attia, Maximos, MD at 5/26/2020 11:00 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 5/15/2020

05/15/2020 Office Visit in Sayre Family Practice

Clinic Notes

Progress Notes

Gillan, Michael F, DO at 5/15/2020 3:40 PM

Author: Gillan, Michael F, DO
Filed: 5/15/2020 3:46 PM
Editor: Gillan, Michael F, DO (Physician)

Service: —
Encounter Date: 5/15/2020

Author Type: Physician
Status: Signed

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 5/15/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Medication Check

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female.

HPI

I have reviewed this patients record on the Pennsylvania PDMP web site.

Patient had contacted me requesting refill of Xanax. She had last been given 15 tablets 8/22/2019. I requested this visit to see what her concerns were and to make sure we were addressing them. She states she has no new issues or concerns. She is trying to make 15 pills last as long as possible.

She does wish to see Orthopedics for right shoulder pain. No injury or inciting event. Has appointment with them 6/23/2020 for knee pain, is hoping they can see her for the shoulder at the same visit.

In our efforts to minimize the spread of COVID-19 in our community, amongst our patients, healthcare staff and providers, we have implemented virtual visits with our patients. No vital signs, physical exam or in-office diagnostics were completed during this visit. These items may be accomplished during subsequent visits. This remote telehealth virtual visit was provided through eGuthrie with Zoom, with the patient located at their home and I was located at my office at the Guthrie Clinic. Patient presented alone.

Patient was seen in a Telemedicine Visit. Informed verbal consent obtained, and the patient agreed to the Telemedicine Visit.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 5/15/2020

05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
• irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008
• PLANTAR FIBROMATOSIS	9/9/2004
• Premenopausal patient	
• Rheumatoid arthritis(714.0)	12/12/2008
• Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
• Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
• Marfan syndrome		
• Heart	Father	
• ?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
• Aortic Dissection, Marfan's Syndrome		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
• ADHD		
• Genetic	Maternal Aunt	
• Marfan syndrome		
• Psychiatry	Other	



Brown, Jennifer Lyn
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Visit date: 5/15/2020

05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

ADHD

- | | |
|----------------------|----------------------|
| • Cancer | Paternal Grandfather |
| • Glaucoma | No family history |
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• Blood Glucose Monitor Software Does not apply Device	1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.
• cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution	INJECT 1 ML INTO THE MUSCLE EVERY 30 DAYS
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• foliC acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• gabapentin (NEURONTIN) 100 MG Oral Cap	Take 3 Caps by mouth EVERY BEDTIME for 60 days.
• Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip	1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred
• Glucose Blood In Vitro Strip	1 Strip by In Vitro route DAILY. One touch verio test strips
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• Lancets Does not apply Misc	by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred
• Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	TAKE 1 TABLET DAILY
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• ondansetron (ZOFRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	TAKE 1 TABLET DAILY



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05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID prn
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS.
- Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab Inject 1 mL of Vit B12 IM every 30 days
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Take 10 mg by mouth TWICE DAILY.
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR TAKE 1 CAPSULE DAILY
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

- Medication
- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History

Socioeconomic History

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
- Partners: Male


GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 5/15/2020

05/15/2020 - Office Visit in Sayre Family Practice (continued)
Clinic Notes (continued)

Birth control/protection: Pill, Condom

Comment: OCPs

Lifestyle

• Physical activity

Days per week: Not on file

Minutes per session: Not on file

• Stress: Not on file

Relationships

• Social connections

Talks on phone: Not on file

Gets together: Not on file

Attends religious service: Not on file

Active member of club or organization: Not on file

Attends meetings of clubs or organizations: Not on file

Relationship status: Not on file

• Intimate partner violence

Fear of current or ex partner: Not on file

Emotionally abused: Not on file

Physically abused: Not on file

Forced sexual activity: Not on file

Other Topics

Concern

• Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:
ROS

Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

The patient denies cough, chest pain, dyspnea, wheezing or hemoptysis.

A focused review of systems was conducted with the patient and is negative unless noted above.

Objective
PHYSICAL EXAM:
VITALS:

No distress

Alert, Oriented

Non labored breathing

Right shoulder has full range of motion, active, on video exam

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM	
1. Chronic right shoulder pain	719.41	M25.511	REFER TO ORTHOPEDICS
	338.29	G89.29	
2. GAD (generalized anxiety disorder)	300.02	F41.1	ALPRAZolam (XANAX) 0.25 MG Oral

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 5/15/2020



05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Tab

Plan

1. Chronic right shoulder pain:
 - Requesting referral to Orthopedics.
 - Reports no numbness, tingling.
 - Reports full range of motion.
 - Unable to examine on video more than active range of motion.
 - Referral placed.
2. GAD:
 - Well controlled.
 - Continue on current therapy.
 - Aware of the risks, benefits, and alternatives to Xanax.
 - 15 tablets is lasting several months.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

See Orthopedics.

Xanax as discussed.

Follow up if symptoms worsen or fail to improve.

As always, please go to the ED with any severe or life threatening symptoms.

Michael F Gillan, DO

Patient Education

Alprazolam (al PRAY zoe lam)

Brand Names: US ALPRAZolam Intensol; ALPRAZolam XR; Xanax; Xanax XR

Brand Names: Canada ALPRAZolam TS; ALPRAZolam-1; APO-Alpraz; APO-Alpraz TS; JAMP-Alprazolam; MYLAN-ALPRAZolam [DSC]; NAT-ALPRAZolam [DSC]; RIVA-ALPRAZolam [DSC]; TEVA-Alprazolam; Xanax; Xanax TS

Warning

- This drug is a benzodiazepine. The use of a benzodiazepine drug along with opioid drugs has led to very bad side effects. Side effects that have happened include slowed or trouble breathing and death. Opioid drugs include drugs like codeine, oxycodone, and morphine. Opioid drugs are used to treat pain and some are used to treat cough. Talk with the doctor.
- If you are taking this drug with an opioid drug, get medical help right away if you feel very sleepy or dizzy; if you have slow, shallow, or trouble breathing; or if you pass out. Caregivers or others need to get medical help right away if the patient does not respond, does not answer or react like normal, or will not wake up.

What is this drug used for?

- It is used to treat anxiety.
- It is used to treat panic attacks.

What do I need to tell my doctor BEFORE I take this drug?

- If you have an allergy to alprazolam or any other part of this drug.

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05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- If you are allergic to this drug; any part of this drug; or any other drugs, foods, or substances. Tell your doctor about the allergy and what signs you had.
- If you have glaucoma.
- If you are taking any of these drugs: Itraconazole or ketoconazole.
- If you are breast-feeding. Do not breast-feed while you take this drug.

This is not a list of all drugs or health problems that interact with this drug. Tell your doctor and pharmacist about all of your drugs (prescription or OTC, natural products, vitamins) and health problems. You must check to make sure that it is safe for you to take this drug with all of your drugs and health problems. Do not start, stop, or change the dose of any drug without checking with your doctor.

What are some things I need to know or do while I take this drug?

All products:

- Tell all of your health care providers that you take this drug. This includes your doctors, nurses, pharmacists, and dentists.
- This drug may be habit-forming with long-term use.
- If you have been taking this drug for a long time or at high doses, it may not work as well and you may need higher doses to get the same effect. This is known as tolerance. Call your doctor if this drug stops working well. Do not take more than ordered.
- Avoid driving and doing other tasks or actions that call for you to be alert until you see how this drug affects you.
- Avoid drinking alcohol while taking this drug.
- Talk with your doctor before you use other drugs and natural products that slow your actions.
- Have your blood work checked if you are on this drug for a long time. Talk with your doctor.
- If you drink grapefruit juice or eat grapefruit often, talk with your doctor.
- If you start or stop smoking, talk with your doctor. How much drug you take may need to be changed.
- If you are 65 or older, use this drug with care. You could have more side effects.
- This drug may cause harm to the unborn baby if you take it while you are pregnant, especially in the first trimester.
- If you are pregnant or you get pregnant while taking this drug, call your doctor right away.

Extended-release tablets:

- Do not stop taking this drug all of a sudden without calling your doctor. You may have a greater risk of signs of withdrawal. This includes seizures. If you need to stop this drug, you will want to slowly stop it as ordered by your doctor.

All other products:

- If you have been taking this drug on a regular basis and you stop it all of a sudden, you may have signs of withdrawal. This includes seizures. Do not stop taking this drug all of a sudden without calling your doctor. Tell your doctor if you have any bad effects.

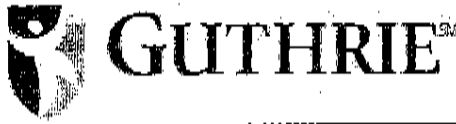
Oral-disintegrating tablet:

- If you have phenylketonuria (PKU), talk with your doctor. Some products have phenylalanine.

What are some side effects that I need to call my doctor about right away?

WARNING/CAUTION: Even though it may be rare, some people may have very bad and sometimes deadly side effects when taking a drug. Tell your doctor or get medical help right away if you have any of the following signs or symptoms that may be related to a very bad side effect:

- Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in the chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat.
- Signs of low mood (depression), thoughts of killing yourself, nervousness, emotional ups and downs, thinking that is not normal, anxiety, or lack of interest in life.
- Change in balance.
- Feeling very sleepy.
- Shortness of breath.
- Very bad dizziness or passing out.
- Feeling confused.
- Memory problems or loss.



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Visit date: 5/15/2020

05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- Trouble speaking.
- Trouble passing urine.
- Period (menstrual) changes.

What are some other side effects of this drug?

All drugs may cause side effects. However, many people have no side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away:

- Feeling sleepy.
- Dizziness.
- Dry mouth.
- Feeling more or less hungry.
- Upset stomach.
- Constipation.
- Change in sex interest.
- Sex problems.
- Feeling tired or weak.
- Weight gain or loss.

These are not all of the side effects that may occur. If you have questions about side effects, call your doctor. Call your doctor for medical advice about side effects.

You may report side effects to your national health agency.

How is this drug best taken?

Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely.

All products:

- Take with or without food. Take with food if it causes an upset stomach.

Liquid (solution):

- Use the dropper that comes with this drug to measure the drug.
- Mix the liquid with water, juice, soda, applesauce, or pudding before taking it.
- Swallow the mixture right away. Do not store for use at a later time.

Oral-disintegrating tablet:

- If the tablets come in a foil blister, do not push the tablet out of the foil when opening. Use dry hands to take it from the foil.
- Place on your tongue and let it dissolve. Water is not needed. Do not swallow it whole. Do not chew, break, or crush it.

Extended-release tablets:

- Swallow whole. Do not chew, break, or crush.

What do I do if I miss a dose?

Extended-release tablets:

- Take a missed dose as soon as you think about it.
- If it is close to the time for your next dose, skip the missed dose and go back to your normal time.
- Do not take 2 doses at the same time or extra doses.

All other products:

- If you take this drug on a regular basis, take a missed dose as soon as you think about it.
- If it is close to the time for your next dose, skip the missed dose and go back to your normal time.
- Do not take 2 doses at the same time or extra doses.
- Many times this drug is taken on an as needed basis. Do not take more often than told by the doctor.

How do I store and/or throw out this drug?

All products:

- Store at room temperature.
- Store in a dry place. Do not store in a bathroom.
- Keep all drugs in a safe place. Keep all drugs out of the reach of children and pets.
- Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so. Check with your pharmacist if you have questions about the best way to throw out drugs. There may be drug take-back programs in your area.

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Brown, Jennifer Lyn

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Visit date: 5/15/2020

05/15/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)**Liquid (solution):**

- Protect from light.
- Throw away any part not used 90 days after opening.

General drug facts

- If your symptoms or health problems do not get better or if they become worse, call your doctor.
- Do not share your drugs with others and do not take anyone else's drugs.
- Some drugs may have another patient information leaflet. If you have any questions about this drug, please talk with your doctor, nurse, pharmacist, or other health care provider.
- If you think there has been an overdose, call your poison control center or get medical care right away. Be ready to tell or show what was taken, how much, and when it happened.

Consumer Information Use and Disclaimer

This information should not be used to decide whether or not to take this medicine or any other medicine. Only the healthcare provider has the knowledge and training to decide which medicines are right for a specific patient. This information does not endorse any medicine as safe, effective, or approved for treating any patient or health condition. This is only a brief summary of general information about this medicine. It does NOT include all information about the possible uses, directions, warnings, precautions, interactions, adverse effects, or risks that may apply to this medicine. This information is not specific medical advice and does not replace information you receive from the healthcare provider. You must talk with the healthcare provider for complete information about the risks and benefits of using this medicine.

Last Reviewed Date

2018-06-08

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Author: Michael F Gillan, DO 5/15/2020 15:43

Electronically signed by Gillan, Michael F, DO at 5/15/2020 3:46 PM



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Office Visit in Sayre Rheumatology

Clinic Notes

Progress Notes

Salam, Arqam, MD at 3/11/2020 1:40 PM

Author: Salam, Arqam, MD

Service: —

Author Type: Resident

Filed: 3/18/2020 2:18 PM

Encounter Date: 3/11/2020

Status: Signed

Editor: Freeman, James, MD (Physician)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 3/11/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Follow Up

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female with a mix of enteropathic arthritis, Crohn's, positive RF, and fibromyalgia who is here for 3 mo f/u

HPI

Pt reports symptoms are not controlled, she reports pain and stiffness in wrists, back and ankles. She saw GI and got repeat Colonoscopy which showed mild Crohn's/UC and discussed with Dr Goergeston about starting Xeljanz in place of stellara for better control of arthropathy on top of IBD. GI wanted Dr Freeman to talk to them for combined plan.

Pt denies any chest pain, abdominal pain, nausea, vomiting, diarrhea, fevers, chills, dysuria, rash.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 3/11/2020

03/11/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- Morbidly obese (HCC)
- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry <i>Anxiety</i>	Mother	
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		
• Heart	Father	
<i>?Marfan's Syndrome</i>		
• Clotting Disorder	Father	
• Heart Disease	Father	
• Heart	Paternal Uncle	
<i>Aortic Dissection, Marfan's Syndrome</i>		
• Heart Disease	Paternal Uncle	
• Diabetes	Maternal Grandfather	
• Thyroid Disease	Maternal Grandfather	
• Macular Degeneration	Paternal Grandmother	
• Psychiatry	Maternal Aunt	
<i>ADHD</i>		
• Genetic	Maternal Aunt	
<i>Marfan syndrome</i>		
• Psychiatry	Other	
<i>ADHD</i>		
• Cancer	Paternal Grandfather	
• Glaucoma	No family history	
• Blindness	No family history	
• Other Eye Problems	No family history	
• Anesth Problems	No family history	

Current Outpatient Medications

Medication	Sig
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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

- ALPRAZolam (XANAX) 0.25 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab Take 1 Tab by mouth EVERY BEDTIME.
- Blood Glucose Monitor Software Does not apply Device 1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR Take 1 Tab by mouth DAILY.
- calcium carbonate (CALTRATE) 600 MG Oral Tab Take 1 Tab by mouth TWICE DAILY.
- Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap Take 1 Cap by mouth DAILY.
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector 0.3 mg by Injection route AS NEEDED (bee sting).
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension Spray 2 Sprays in nose DAILY.
- foliC acid 1 MG Oral Tab Take 1 Tab by mouth DAILY.
- gabapentin (NEURONTIN) 100 MG Oral Cap Take 3 Caps by mouth EVERY BEDTIME for 60 days.
- Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip 1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred
- Glucose Blood In Vitro Strip 1 Strip by In Vitro route DAILY. One touch verio test strips
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc 1 Each by Does not apply route EVERY 7 DAYS.
- Lancets Does not apply Misc by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred
- Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab Take 1 Tab by mouth DAILY.
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab TAKE 1 TABLET DAILY
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab Take 1 Tab by mouth DAILY.
- mometasone (NASONEX) 50 MCG/ACT Nasal Suspension Spray 1 Spray in nose EVERY TWELVE HOURS.
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
- pantoprazole (PROTONIX) 40 MG Oral Tab EC TAKE 1 TABLET DAILY
- Probiotic Product (VSL#3) Oral Cap Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab Take 3 Tabs by mouth TWICE DAILY.
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
- Tofacitinib Citrate (XELJANZ) 10 MG Oral Tab Take 10 mg by mouth TWICE DAILY.
- Ustekinumab 90 MG/ML Inject 90 mg beneath the skin AS DIRECTED. Inject



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Office Visit in Sayre Rheumatology (continued)**Clinic Notes (continued)**

- Subcutaneous Solution Prefilled Syringe every 8 weeks. Indications: Crohn's Disease
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR Take 1 Cap by mouth DAILY.
 - venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR Take 2 Caps by mouth DAILY.

Current Facility-Administered Medications

- Medication
- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History**Socioeconomic History**

- Marital status: Separated
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity
 - Worry: Not on file
 - Inability: Not on file
- Transportation needs
 - Medical: Not on file
 - Non-medical: Not on file

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: No
- Alcohol/week: 0.0 standard drinks
- Drug use: No
- Sexual activity: Yes
 - Partners: Male
 - Birth control/protection: Pill, Condom
 - Comment: OCPs

Lifestyle

- Physical activity
 - Days per week: Not on file
 - Minutes per session: Not on file
- Stress: Not on file

Relationships

- Social connections



Brown, Jennifer Lyn

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03/11/2020 - Office Visit in Sayre Rheumatology (continued)

Clinic Notes (continued)

Talks on phone:	Not on file
Gets together:	Not on file
Attends religious service:	Not on file
Active member of club or organization:	Not on file
Attends meetings of clubs or organizations:	Not on file
Relationship status:	Not on file
• Intimate partner violence	
Fear of current or ex partner:	Not on file
Emotionally abused:	Not on file
Physically abused:	Not on file
Forced sexual activity:	Not on file

Other Topics Concern

- Not on file

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

ROS

Complete review of system is negative except as above.

Objective

PHYSICAL EXAM:

VITALS: BP 128/80 | Ht 5' 11" (1.803 m) | Wt 291 lb (132 kg) | BMI 40.59 kg/m² Body mass index is 40.59 kg/m².

Physical Exam

Alert, oriented x3. Not in Distress

General: cooperative

Heart: regular rate & rhythm, S1 S2 heard and no murmur,

Lungs: Clear to auscultation bilaterally

MSK: tenderness and stiffness in lumbar back, wrists and ankles

Abd: soft, nontender, nondistended, BS present

Ext: no edema

Neuro: No gross focal deficits

ASSESSMENT / IMPRESSION:

	ICD-9-CM	ICD-10-CM
1. Enteropathic arthritis	713.1	M07.60
2. Fibromyalgia	729.1	M79.7



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Office Visit in Sayre Rheumatology (continued)**Clinic Notes (continued)****Plan****Seropositive RA in settings of Crohn's/UC, Enteropathic Arthritis/FM**

Symptoms not under control on current regimen of SSZ 1.5 gBID, MTX 12.5, Stellara and Amtriptyline

Will stop MTX and discuss starting on Xekjanz 10 mg BID with GI and monitor response.

The risks, benefits, and options to xekjanz were detailed.

Will give gabapentin for pain and sleep disturbances

Continue following GI for Crohns/UC

Patient Instructions

Will start you on Xekjanz 10 mg Twice Daily. STOP Stellara once it gets approved

Take gabapentin for pain and sleep. 300 mg at night Daily

Stop taking Methotrexate

Will see you in 3 months with blood work

Discussed with and agreed upon with Dr Freeman

Author: Arqam Salam, MD 3/11/2020 18:01

Electronically signed by Freeman, James. MD at 3/18/2020 2:18 PM



Brown, Jennifer Lyn

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Visit date: 3/11/2020

03/11/2020 - Lab in Sayre Laboratory

Labs

CALPROTECTIN, STOOL [169308288] (Active)

Status: Active

Electronically signed by: Yousef, Mohammad, MD on 12/18/19 1514

Ordering user: Yousef, Mohammad, MD 12/18/19 1514

Ordering provider: Yousef, Mohammad, MD

Authorized by: Yousef, Mohammad, MD

Ordering mode: Standard

Cosigning events

Electronically cosigned by Lincoln, Matthew J, DO 12/22/19 1145 for Ordering

Frequency: Routine 12/18/19 -

Class: Guthrie

Quantity: 1

Instance released by: Firestone, Lauralee 3/11/2020 1:21 PM

Diagnoses

Crohn's disease of colon without complication (HCC) [K50.10]

Specimen Information

ID	Type	Source	Collected By
—	Stool	—	—

Indications

Crohn's disease of colon without complication (HCC) [K50.10 (ICD-10-CM)]

COMPREHENSIVE METABOLIC PANEL [169308289] (Final result)

Status: Completed

Electronically signed by: Jewell, Jan, RN on 12/03/19 1004

Ordering user: Jewell, Jan, RN 12/03/19 1004

Ordering provider: Freeman, James, MD

Authorized by: Freeman, James, MD

Ordering mode: Standard

Cosigning events

Electronically cosigned by Freeman, James, MD 03/29/20 1752 for Ordering

Frequency: Routine 12/03/19 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Firestone, Lauralee 3/11/2020 1:21 PM

Diagnoses

High risk medication use [Z79.899]

Specimen Information

ID	Type	Source	Collected By
GC20-071C1026	Blood	Blood - Veni	Firestone, Lauralee 03/11/20 1323

COMPREHENSIVE METABOLIC PANEL [169308289]

Resulted: 03/11/20 1354, Result status: Final result

Ordering provider: Freeman, James, MD 03/11/20 1321

Order status: Completed

Filed by: Interface, Lab Orders 03/11/20 1354

Collected by: Firestone, Lauralee 03/11/20 1323

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
Sodium	137	134 - 145 mmol/L	—	GMG
Potassium	3.8	3.5 - 5.1 mmol/L	—	GMG
Chloride	101	98 - 107 mmol/L	—	GMG
CO2	29	22 - 30 mmol/L	—	GMG
Calcium	9.0	8.3 - 10.1 mg/dl	—	GMG
Albumin	4.3	3.5 - 5.0 g/dl	—	GMG
BUN	13	7 - 17 mg/dl	—	GMG
Creatinine	0.7	0.7 - 1.2 mg/dl	—	GMG
Glucose	93	70 - 99 mg/dl	—	GMG
Total Protein	7.7	6.3 - 8.2 g/dl	—	GMG
Total Bilirubin	0.4	0.0 - 1.1 MG/DL	—	GMG
AST	28	15 - 46 U/L	—	GMG
ALT	22	9 - 52 U/L	—	GMG
Alkaline Phosphatase	53	40 - 150 U/L	—	GMG
eGFR	>60	See Interpretation	—	GMG
		Below		
		ml/min/1.73ml Sq		

Comment:

1015


GUTHRIE

Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Lab in Sayre Laboratory (continued)
Labs (continued)
Estimated GFR Interpretation:
Above 60ml/min/1.73m² = Normal Renal Function30-59 ml/min/1.73m² = Stage 3 Chronic Kidney Disease15-29 ml/min/1.73m² = Stage 4 Chronic Kidney DiseaseLess than 15 ml/min/1.73m² = Stage 5 Chronic Kidney Disease

The GFR value is calculated using the Modification of Diet in Renal Disease (MDRD) Study Equation which can be found at:

<https://www.kidney.org/content/mdrd-study-equation>

BUN/Creatinine Ratio	19	6 - 22 RATIO	—	GMG
Anion Gap	7	3 - 11 mmol/L	—	GMG
A/G Ratio	1.3	0.8 - 2.0 ratio	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

High risk medication use [Z79.899 (ICD-10-CM)]

CBC WITH DIFFERENTIAL [169308290] (Final result)

Status: Completed

Electronically signed by: Jewell, Jan, RN on 12/03/19 1004

Ordering user: Jewell, Jan, RN 12/03/19 1004

Ordering provider: Freeman, James, MD

Authorized by: Freeman, James, MD

Ordering mode: Standard

Cosigning events

Electronically cosigned by Freeman, James, MD 03/29/20 1752 for Ordering

Frequency: Routine 12/03/19 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Firestone, Lauralee 3/11/2020 1:21 PM

Diagnoses

High risk medication use [Z79.899]

Specimen Information

ID	Type	Source	Collected By
GC20-071H0613	Blood	Blood - Veni	Firestone, Lauralee 03/11/20 1323

CBC WITH DIFFERENTIAL [169308290] (Abnormal)

Resulted: 03/11/20 1337, Result status: Final result

Ordering provider: Freeman, James, MD 03/11/20 1321

Order status: Completed

Filed by: Interface, Lab Orders 03/11/20 1337

Collected by: Firestone, Lauralee 03/11/20 1323

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Components

Component	Value	Reference Range	Flag	Lab
WBC Count	7.40	3.98 - 10.04 K/uL	—	GMG
RBC Count	4.64	3.93 - 5.22 M/uL	—	GMG
Hemoglobin	13.0	11.2 - 15.7 g/dL	—	GMG
Hematocrit	40.6	34.1 - 44.9 %	—	GMG
MCV	87.5	79.4 - 94.8 fL	—	GMG
MCH	28.0	25.6 - 32.2 pg	—	GMG
MCHC	32.0	32.2 - 35.5 g/dL	L	GMG
Platelet Count	313	182 - 369 K/uL	—	GMG
MPV	9.4	9.4 - 12.3 fL	—	GMG
RDW	12.7	11.7 - 14.4 %	—	GMG
Neutrophil %	52.2	34.0 - 71.1 %	—	GMG

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GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/11/2020

03/11/2020 - Lab in Sayre Laboratory (continued)
Labs (continued)

Lymphocyte %	33.6	19.3 - 51.7 %	—	GMG
Monocyte %	10.4	4.7 - 12.5 %	—	GMG
Eosinophil %	2.6	0.7 - 5.8 %	—	GMG
Basophil %	0.9	0.1 - 1.2 %	—	GMG
nRBC %	0.0	0.0 - 0.2 %	—	GMG
Neutrophil #	3.86	1.56 - 6.13 K/uL	—	GMG
Lymphocyte #	2.49	1.18 - 3.74 K/uL	—	GMG
Monocyte #	0.77	0.24 - 0.86 K/uL	—	GMG
Eosinophil #	0.19	0.04 - 0.36 K/uL	—	GMG
Basophil #	0.07	0.01 - 0.08 K/uL	—	GMG
Immature Gran %	0.3	0.0 - 0.4 %	—	GMG
Immature Gran #	0.02	0.00 - 0.03 K/uL	—	GMG
NRBC #	0.00	0.00 - 0.12 K/uL	—	GMG

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG		GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

High risk medication use [Z79.899 (ICD-10-CM)]



Brown, Jennifer Lyn

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Visit date: 1/22/2020

01/22/2020 Lab in Sayre Laboratory

Labs

PROINSULIN [168104681] (Final result)

Status: Completed

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Authorized by: Gillan, Michael F, DO

Frequency: Routine 01/17/20 -

Quantity: 1

Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM

Diagnoses

Low blood sugar [E16.2]

Ordering provider: Gillan, Michael F, DO

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
QU20-022Q0078	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

PROINSULIN [168104681]

Resulted: 02/01/20 1405, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927

Order status: Completed

Filed by: Quest, Results Interface 02/01/20 1410

Collected by: Pruyne, Sandy 01/22/20 0929

Resulting lab: QUEST DIAGNOSTICS

Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Components

Component	Value	Reference Range	Flag	Lab
Proinsulin	5.6	< OR = 18.8 pmol/L	—	36

Comment:

This test was developed and its analytical performance characteristics have been determined by Quest Diagnostics Nichols Institute San Juan Capistrano. It has not been cleared or approved by FDA. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST DIAGNOSTICS	Unknown	875 GREENTREE RD 4 PARKWAY CENTER PITTSBURGH PA 15220	09/26/11 1434 - Present

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

BETA HYDROXYBUTYRATE [168104682] (Final result)

Status: Completed

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Authorized by: Gillan, Michael F, DO

Frequency: Routine 01/17/20 -

Quantity: 1

Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM

Diagnoses

Low blood sugar [E16.2]

Ordering provider: Gillan, Michael F, DO

Ordering mode: Standard

Class: Interface

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
			1018



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/22/2020

01/22/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

GC20-022C0534 Blood Blood - Veni Pruyne, Sandy 01/22/20 0929

BETA HYDROXYBUTYRATE [168104682] (Normal)

Resulted: 01/22/20 1208, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927
Filed by: Interface, Lab Orders 01/22/20 1208
Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY
Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Order status: Completed
Collected by: Pruyne, Sandy 01/22/20 0929

Components

Component	Value	Reference Range	Flag	Lab
Beta Hydroxybutyrate	0.19	0.02 - 0.27 mmol/L	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

C PEPTIDE [168104683] (Final result)

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520
Ordering user: Gillan, Michael F, DO 01/17/20 1520
Authorized by: Gillan, Michael F, DO
Frequency: Routine 01/17/20 -
Quantity: 1
Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM
Diagnoses
Low blood sugar [E16.2]

Status: Completed

Ordering provider: Gillan, Michael F, DO
Ordering mode: Standard
Class: Guthrie
Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
QU20-022Q0079	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

C PEPTIDE [168104683]

Resulted: 01/23/20 1440, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927
Filed by: Quest, Results Interface 01/23/20 1445
Resulting lab: QUEST DIAGNOSTICS
Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Order status: Completed
Collected by: Pruyne, Sandy 01/22/20 0929

Components

Component	Value	Reference Range	Flag	Lab
C-Peptide	3.18	0.80 - 3.85 NG/ML	—	36

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST DIAGNOSTICS	Unknown	875 GREENTREE RD 4 PARKWAY CENTER PITTSBURGH PA	09/26/11 1434 - Present

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Brown, Jennifer Lyn

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Visit date: 1/22/2020

01/22/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

15220

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

GLUCOSE, BLOOD FASTING [168104684] (Final result)

Status: Completed

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Authorized by: Gillan, Michael F, DO

Frequency: Routine 01/17/20 -

Quantity: 1

Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM

Diagnoses

Low blood sugar [E16.2]

Ordering provider: Gillan, Michael F, DO

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
GC20-022C0534	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

GLUCOSE, BLOOD FASTING [168104684] (Normal)

Resulted: 01/22/20 1026, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927

Order status: Completed

Filed by: Interface, Lab Orders 01/22/20 1026

Collected by: Pruyne, Sandy 01/22/20 0929

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Components

Component	Value	Reference Range	Flag	Lab
Glucose, FBS (Lab)	87	70 - 99 MG/DL	—	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

INSULIN LEVEL [168104685] (Final result)

Status: Completed

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Authorized by: Gillan, Michael F, DO

Frequency: Routine 01/17/20 -

Quantity: 1

Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM

Diagnoses

Low blood sugar [E16.2]

Ordering provider: Gillan, Michael F, DO

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

1020



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/22/2020

01/22/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

ID	Type	Source	Collected By
QU20-022Q0077	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

INSULIN LEVEL [168104685] (Abnormal)

Resulted: 01/23/20 1348, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927

Order status: Completed

Filed by: Quest, Results Interface 01/23/20 1355

Collected by: Pruyn, Sandy 01/22/20 0929

Resulting lab: QUEST DIAGNOSTICS

Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Components

Component	Value	Reference Range	Flag	Lab
Insulin Level	20.1	2.0 - 19.6 MICRO IU/ML	H ^	36

Comment:

THIS INSULIN ASSAY SHOWS STRONG CROSS-REACTIVITY FOR SOME
INSULIN ANALOGS (LISPRO, ASPART, AND GLARGINE) AND MUCH
LOWER CROSS-REACTIVITY WITH OTHERS (DETEMIR, GLULISINE).

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
36 - Unknown	QUEST DIAGNOSTICS	Unknown		875 GREENTREE RD 4 PARKWAY CENTER PITTSBURGH PA 15220	09/26/11 1434 - Present

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

VITAMIN D 25 HYDROXY (GUTHRIE) [168104686] (Final result)

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Status: Completed

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Ordering provider: Gillan, Michael F, DO

Authorized by: Gillan, Michael F, DO

Ordering mode: Standard

Frequency: Routine 01/17/20 -

Class: Guthrie

Quantity: 1

Lab status: Final result

Instance released by: Pruyn, Sandy 1/22/2020 9:27 AM

Diagnoses

Memory loss [R41.3]

Specimen Information

ID	Type	Source	Collected By
GC20-022C0534	Blood	Blood - Veni	Pruyn, Sandy 01/22/20 0929

VITAMIN D 25 HYDROXY (GUTHRIE) [168104686] (Abnormal)

Resulted: 01/22/20 1040, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927

Order status: Completed

Filed by: Interface, Lab Orders 01/22/20 1040

Collected by: Pruyn, Sandy 01/22/20 0929

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Narrative:

Interpretation:

<20 ng/ml Deficiency

20-<30 ng/ml Insufficiency

32-100 ng/ml Sufficiency



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/22/2020

01/22/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

>100 ng/ml Potential Toxicity

Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Components

Component	Value	Reference Range	Flag	Lab
Vitamin D 25 HYDROXY	31.0	32.0 - 100.0 ng/ml	L	GMG

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Memory loss [R41.3 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

GLYCOHEMOGLOBIN A1C [168104687] (Final result)

Status: Completed

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520

Ordering user: Gillan, Michael F, DO 01/17/20 1520

Authorized by: Gillan, Michael F, DO

Frequency: Routine 01/17/20 -

Quantity: 1

Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM

Diagnoses

Low blood sugar [E16.2]

Scheduling instructions

No results found for: GLYCO

Ordering provider: Gillan, Michael F, DO

Ordering mode: Standard

Class: Guthrie

Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
GC20-022S0101	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

GLYCOHEMOGLOBIN A1C [168104687] (Normal)

Resulted: 01/22/20 1301, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927

Filed by: Shay, Thomas 01/22/20 1301

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY

Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Order status: Completed

Collected by: Pruyne, Sandy 01/22/20 0929

Components

Component	Value	Reference Range	Flag	Lab
Glycohemoglobin A1C	5.1	<=5.6 %	—	GMG
Comment:				
Normal*: <=5.6%				
Pre Diabetes* Risk: 5.7-6.4%				
Diabetes* Risk: >=6.5%				
Glycemic Goals for Adult Diabetes*: <7.0%				

*(Adult Ranges)American Diabetes Association, Standards of Medical Care in Diabetes, 2018



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/22/2020

01/22/2020 - Lab in Sayre Laboratory (continued)

Labs (continued)

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG		GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Low blood sugar [E16.2 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM

THYROID STIMULATING HORMONE [168104688] (Final result)

Electronically signed by: Gillan, Michael F, DO on 01/17/20 1520
Ordering user: Gillan, Michael F, DO 01/17/20 1520
Authorized by: Gillan, Michael F, DO
Frequency: Routine 01/17/20 -
Quantity: 1
Instance released by: Pruyne, Sandy 1/22/2020 9:27 AM
Diagnoses
Memory loss [R41.3]

Status: Completed

Ordering provider: Gillan, Michael F, DO
Ordering mode: Standard
Class: Guthrie
Lab status: Final result

Specimen Information

ID	Type	Source	Collected By
GC20-022C0534	Blood	Blood - Veni	Pruyne, Sandy 01/22/20 0929

THYROID STIMULATING HORMONE [168104688] (Normal)

Resulted: 01/22/20 1054, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0927
Filed by: Interface, Lab Orders 01/22/20 1054
Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY
Acknowledged by: Gillan, Michael F, DO on 02/02/20 0624

Order status: Completed
Collected by: Pruyne, Sandy 01/22/20 0929

Components

Component	Value	Reference Range	Flag	Lab
TSH	1.70	0.47 - 4.68 ulu/ml	—	GMG

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
6 - GMG		GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Memory loss [R41.3 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 2/2/2020 6:24 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice

Clinic Notes

Progress Notes

Gillan, Michael F, DO at 1/17/2020 2:40 PM

Author: Gillan, Michael F, DO

Filed: 1/20/2020 11:56 AM

Editor: Gillan, Michael F, DO (Physician)

Service: —

Encounter Date: 1/17/2020

Author Type: Physician

Status: Signed

PATIENT: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
DATE OF SERVICE: 1/17/2020

CHIEF COMPLAINT:

Chief Complaint

Patient presents with:

- Discuss Patient Care

Subjective

HISTORY OF PRESENT ILLNESS:

Jennifer Lyn Brown is a 43-y.o. female. She presents with her significant other.

HPI

1. Low sugar: Patient states she was diagnosed with this before. She states once or twice a week she will feel "yucky." States that it usually occurs around 2 to 3 pm. States that she will feel "weak." No focal weakness. No loss of bowel or bladder control. No vision changes. No pre-syncopal or syncopal symptoms. No nausea or vomiting. States she will eat or drink something and it quickly resolves. She has not been able to identify any triggers. Not skipping meals. She believes her sugar gets low when this occurs but has not had it tested.

2. Disability: Patient states her lawyer told her to have disability paperwork filled out. Patient states she brought both the "physical disability" and "mental health disability" forms with her. She states it is up to me, the provider, to determine which one of the two needs to be filled out.

From a mental health and physical prospective:

- Patient states she has not worked since May of 2019.
- Patient states that she has two auto immune diseases.
- Patient states her Crohn's disease is followed by GI and states it seems to be well controlled.
- Patient states he RA is followed by Rheumatology and is not well controlled. - She states her manager at her prior job and the patient mutually decided patient should "step down."
- She states she is not currently on disability.
- She states that the stress of her job was making her RA and pain worse.
- She states her Rheumatologist diagnosed her with Fibromyalgia as well.
- She states while she was working she saw a provider/counselor in the Employee Assistance Program (EAP) that "helped a lot."
- States she saw someone in employee health, patient claims that provider told her "yeah you should be on disability."
- She states she has applied for disability prior and it was denied.
- States that she feels like she has "brain fog" or "memory loss" is this same time frame. States she can recall long term events. States trouble remembering conversations. States not getting lost of forgetting to leave the stove on (or anything similar to this).

Past Medical History:

Diagnosis

- Anal fissure

Date

1/2013

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Anxiety	
• Attention deficit	3/18/2014
• Back ache	6/30/2008
• Calcaneal spur	8/9/2016
• Cherry angioma	
• Cholecystitis	5/23/2005
• CHRONIC SINUSITIS NOS	
CT 2005	
• Crohn disease (HCC)	1/20/2014
• Depression	10/7/2008
• Endocrine problem	
• Epicondylitis elbow, medial	8/20/2014
• Fatty liver	
• Fibromyalgia	
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	1/18/2011
• Nontoxic multinodular goiter	
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	10/7/2008
• Physiological ovarian cysts	9/9/2004
• PLANTAR FIBROMATOSIS	
• Premenopausal patient	12/12/2008
• Rheumatoid arthritis(714.0)	
Sees Dr. Freeman in Elmira.	
• Severe obstructive sleep apnea	6/10/2013
• Sleep apnea	
• Thyroid nodule	6/3/2010
• Wrist fracture	

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
Anxiety		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
Marfan syndrome		
• Heart	Father	
?Marfan's Syndrome		
• Clotting Disorder	Father	
• Heart Disease	Father	



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

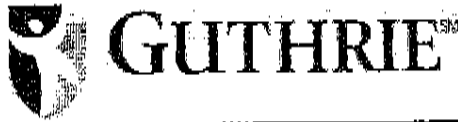
01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

• Heart	Paternal Uncle
<i>Aortic Dissection, Marfan's Syndrome</i>	
• Heart Disease	Paternal Uncle
• Diabetes	Maternal Grandfather
• Thyroid Disease	Maternal Grandfather
• Macular Degeneration	Paternal Grandmother
• Psychiatry	Maternal Aunt
ADHD	
• Genetic	Maternal Aunt
<i>Marfan syndrome</i>	
• Psychiatry	Other
ADHD	
• Cancer	Paternal Grandfather
• Glaucoma	No family history
• Blindness	No family history
• Other Eye Problems	No family history
• Anesth Problems	No family history

Current Outpatient Medications

Medication	Sig
• ALPRAZolam (XANAX) 0.25 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg.
• amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab	Take 1 Tab by mouth EVERY BEDTIME.
• Blood Glucose Monitor Software	1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred
Does not apply Device	
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.
• Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap	Take 1 Cap by mouth DAILY.
• cyclobenzaprine (FLEXERIL) 10 MG Oral Tab	Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm.
• EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector	0.3 mg by Injection route AS NEEDED (bee sting).
• fluconazole (DIFLUCAN) 200 MG Oral Tab	Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• folic acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip	1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• Lancets Does not apply Misc	by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20	Take 1 Tab by mouth DAILY.



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

- | | |
|---|---|
| MG Oral Tab | |
| • loratadine (CLARITIN, ALAVERT) | Take 1 Tab by mouth DAILY. |
| 10 MG Oral Tab | |
| • methotrexate sodium, PF, (MTX) | Inject 0.5 mL beneath the skin EVERY SATURDAY. |
| 50 MG/2ML Injection Solution | |
| • mometasone (NASONEX) 50 | Spray 1 Spray in nose EVERY TWELVE HOURS. |
| MCG/ACT Nasal Suspension | |
| • ondansetron (ZOFTRAN ODT) 8 | Take 1 Tab by mouth EVERY EIGHT HOURS AS |
| MG Oral TABLET DISPERSIBLE | NEEDED for nausea. |
| • pantoprazole (PROTONIX) 40 MG | Take 1 Tab by mouth DAILY. |
| Oral Tab EC | |
| • Probiotic Product (VSL#3) Oral | Take 1 Cap by mouth DAILY 0700 on Empty Stomach. |
| Cap | May increase to BID pm |
| • sulfasalazine (AZULFIDINE) 500 | Take 3 Tabs by mouth TWICE DAILY. |
| MG Oral Tab | |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. |
| | Vitamin B12 IM |
| • Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc | Inject 1 mL within a muscle EVERY THIRTY DAYS. |
| | Inject 1 mL of Vit B12 IM every 30 days |
| • Ustekinumab 90 MG/ML | Inject 90 mg beneath the skin AS DIRECTED. Inject |
| Subcutaneous Solution Prefilled Syringe | every 8 weeks. Indications: Crohn's Disease |
| • venlafaxine (EFFEXOR XR) 150 | Take 1 Cap by mouth DAILY. |
| MG Oral CAPSULE SR 24 HR | |
| • venlafaxine (EFFEXOR XR) 37.5 | Take 2 Caps by mouth DAILY. |
| MG Oral CAPSULE SR 24 HR | |

Current Facility-Administered Medications

- Medication
- saline (OCEAN) nasal spray 0.65 %

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Social History

Socioeconomic History

- | | |
|----------------------------|-------------|
| • Marital status: | Separated |
| Spouse name: | Not on file |
| • Number of children: | Not on file |
| • Years of education: | Not on file |
| • Highest education level: | Not on file |

Occupational History

- Not on file

Social Needs

- | | |
|------------------------------|-------------|
| • Financial resource strain: | Not on file |
| • Food insecurity | |
| Worry: | Not on file |
| Inability: | Not on file |
| • Transportation needs | |


GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)
Clinic Notes (continued)

Medical:	Not on file
Non-medical:	Not on file
Tobacco Use	
• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
Substance and Sexual Activity	
• Alcohol use:	No
Alcohol/week:	0.0 standard drinks
• Drug use:	No
• Sexual activity:	Yes
Partners:	Male
Birth control/protection:	Pill, Condom
<i>Comment: OCPs</i>	
Lifestyle	
• Physical activity	
Days per week:	Not on file
Minutes per session:	Not on file
• Stress:	Not on file
Relationships	
• Social connections	
Talks on phone:	Not on file
Gets together:	Not on file
Attends religious service:	Not on file
Active member of club or organization:	Not on file
Attends meetings of clubs or organizations:	Not on file
Relationship status:	Not on file
• Intimate partner violence	
Fear of current or ex partner:	Not on file
Emotionally abused:	Not on file
Physically abused:	Not on file
Forced sexual activity:	Not on file
Other Topics	
• Not on file	Concern

Social History Narrative

August 2016: Works at Guthrie GI department. Lives with husband, has no children.

REVIEW OF SYSTEMS:

ROS

A comprehensive review of systems was conducted with the patient and is negative unless noted above.

Objective
PHYSICAL EXAM:

VITALS: BP 126/84 (BP Location: Left arm, Patient Position: Sitting) | Pulse 84 | Temp 99.1 °F (37.3 °C) (Tympanic) | Resp 18 | Ht 5' 11" (1.803 m) | Wt 280 lb (127 kg) | SpO2 100% | BMI 39.05 kg/m² Body mass index is 39.05 kg/m².

Physical Exam

Vitals signs and nursing note reviewed.

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Constitutional:

General: She is not in acute distress.

Appearance: Normal appearance. She is not ill-appearing, toxic-appearing or diaphoretic.

HENT:

Head: Normocephalic and atraumatic.

Nose: Nose normal.

Mouth/Throat:

Mouth: Mucous membranes are moist.

Pharynx: No oropharyngeal exudate or posterior oropharyngeal erythema.

Eyes:

Extraocular Movements: Extraocular movements intact.

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Neck:

Musculoskeletal: Normal range of motion and neck supple.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Heart sounds: Normal heart sounds. No murmur. No friction rub. No gallop.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No stridor. No wheezing, rhonchi or rales.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness. There is no right CVA tenderness, left CVA tenderness, guarding or rebound.

Musculoskeletal:

Comments: States hands and back are most impacted by her condition. Grip strength 5/5 bilaterally.

Ambulated into office without assistance. Able to get onto and off exam table without assistance.

Skin:

General: Skin is warm and dry.

Capillary Refill: Capillary refill takes less than 2 seconds.

Neurological:

General: No focal deficit present.

Mental Status: She is alert. Mental status is at baseline.

Cranial Nerves: No cranial nerve deficit.

Motor: No weakness.

Gait: Gait normal.

Psychiatric:

Mood and Affect: Mood normal.

Behavior: Behavior normal.

Thought Content: Thought content normal.

Judgment: Judgment normal.

ASSESSMENT / IMPRESSION:

	CD-9-CM	CD-10-CM	
1. Memory loss	780.93	R41.3	THYROID STIMULATING HORMONE VITAMIN D 25 HYDROXY (GUTHRIE) REFER TO NEUROLOGY REFER TO PSYCHIATRY

GUTHRIESM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

2.	Low blood sugar	251.2	E16.2	GLYCOHEMOGLOBIN A1C Blood Glucose Monitor Software Does not apply Device Lancets Does not apply Misc Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip INSULIN LEVEL GLUCOSE, BLOOD FASTING C PEPTIDE BETA HYDROXYBUTYRATE PROINSULIN
3.	Stress reaction	308.9	F43.0	REFER TO PSYCHIATRY

Plan

1. Memory Loss:
 - Will need to complete MMSE at next visit.
 - Memory worsened after she left her job, per the patient.
 - We will refer her to Psychiatry for evaluation and treatment. Patient agreeable.
 - We will work her up for secondary causes and refer her to Neurology as well.
2. For her low blood sugar symptoms:
 - Will obtain testing to confirm.
 - She has history of gastric sleeve, may need to follow up with Bariatrics and/or Endocrinology after testing completed.
3. Will review her paperwork.
 - May need information from Rheumatology.
 - Patient decided to pursue the disability paperwork from a physical perspective as opposed to mental health.
 - May need to obtain Functional Capacity Testing.

Follow up after testing, sooner as needed.

The risks, benefits, and alternatives to the above were discussed with the patient. All questions and concerns addressed to the satisfaction of patient. They will call with any questions or concerns. They will go to the ED with any severe or life threatening symptoms. They will follow up as directed.

Patient Instructions

Blood work on two orange.

See Neurology and Psychiatry.

I will talk to Dr. Freeman about your paperwork.

Follow up 40 minute appointment in 6 to 8 weeks.

Michael F Gillan, DO



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 1/17/2020

01/17/2020 - Office Visit in Sayre Family Practice (continued)

Clinic Notes (continued)

Author: Michael F Gillan, DO 1/20/2020 10:58

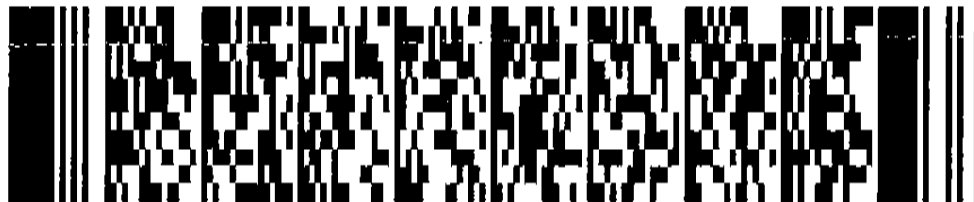
Electronically signed by Gillan, Michael F, DO at 1/20/2020 11:56 AM

INSERT THIS END FIRST

**Please include this barcode cover sheet as the first page
of each set of documents returned.**

Fax the evidence to this fax number:

877-304-5049



RQID:0000000000000000278425518 SITE:X02 DR:S
SSN:132582507 DOCTYPE:5032 RF:D CS:195d

Claimant: Jennifer Brown
SSN: 132-58-2507

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FOSTER LAW OFFICE

EXHIBIT NO. B14F

PAGE: 1 OF 76

Jonathan P. Foster Sr., Esquire, of Counsel
Email: Jonathan.Sr@fosterslawfirm.com

303 South Keystone Avenue
Sayre, PA 18840
Phone: (570) 888-1529
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www.fosterslawfirm.com

Jonathan P. Foster Jr., Esquire
Email: Jonathan.Jr@fosterslawfirm.com

PRIVILEGED AND CONFIDENTIAL

July 14, 2020

Syracuse, NY OHO
P.O. Box 9045
London, KY 40742-9045

RE: Jennifer Brown
SSN: 132-58-2507

Dear Ladies and Gentlemen:

Enclosed herein please find the following medical records to be included in the above referenced file.

- Robert Packer Hospital – 01/07/2019 through 06/23/2020

Should you have any questions or concerns, please do not hesitate to contact my law office.

Sincerely,
FOSTER LAW OFFICE

JONATHAN P. FOSTER, JR., ESQUIRE

JPF.Jr./jns



Brown, Jennifer Lyn

PAGE: 2 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

01/07/2019 - FOLLOW UP in RPH Physical Therapy

Clinic Notes

Therapy Plan of Care

Fritzen, Michael, PT at 1/7/2019 5:18 PM

Author: Fritzen, Michael, PT

Service: ORTHOPEDIC

Author Type: Physical Therapist

Filed: 1/7/2019 5:20 PM

Date of Service: 1/7/2019 5:18 PM

Status: Signed

Editor: Fritzen, Michael, PT (Physical Therapist)

Cosigner: Gorsline, Michael, PA-C at
1/8/2019 10:28 AM

The Guthrie Clinic
Re-Evaluation Plan of Care
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
 1 Guthrie Square
 Sayre PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 1/7/2019

Referring Physician: Michael Gorsline

Plan of Care Start Date: 01/07/19

Plan of Care Expiration Date: 04/07/19

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Plantar fascial fibromatosis	728.71	M72.2

Prior Functional Status: walking a lot

Current Functional Status:

not walking dog

Rehabilitative Prognosis: Good

Goals:

Short Goals: (2-4 wks)

1) IND education -- MET

2) IND 1st step pain control -- MET

3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

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Brown, Jennifer Lyn

PAGE: 3 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/7/2019, D/C: 1/7/2019

01/07/2019 - FOLLOW UP in RPH Physical Therapy (continued)

Clinic Notes (continued)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- PROGRESSING
- 4) resume walking dog pain limited -- NOT MET

Planned Intervention(s): Gait Training (97116);Therapeutic Activity (Timed) (97530);Therapeutic Exercise (Timed) (97110);Ultrasound (Timed) (97035);Manual Therapy (Timed) (97140);Ortho (Fit) Training (Timed) (97760);Orthotic Follow Up (97763);Self Care Instructions (Timed) (97535)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: Other (see Comment)(1/1-3 wks)

Duration of Treatment: 3 months

The Physical Therapy Plan of Care has been discussed with the patient . Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under my care.

Gorsline, Michael, PA-C

1 GUTHRIE SQUARE

SAYRE, PA 18840 (To be Electronically signed)

Author: Michael Fritzen, PT 1/7/2019 17:20

Electronically signed by Fritzen, Michael, PT at 1/7/2019 5:20 PM

Electronically signed by Gorsline, Michael, PA-C at 1/8/2019 10:28 AM



Brown, Jennifer Lyn

EXHIBIT NO. B14F

PAGE: 4 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/1/2019, D/C: 2/1/2019

02/01/2019 - FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Fritzen, Michael, PT at 2/1/2019 12:05 PM

Author: Fritzen, Michael, PT

Service: —

Author Type: Physical Therapist

Filed: 2/1/2019 12:25 PM

Date of Service: 2/1/2019 12:05 PM

Status: Signed

Editor: Fritzen, Michael, PT (Physical Therapist)

The Guthrie Clinic

DISCHARGE Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 Guthrie Square

Sayre PA 18840-1625

Tel 570-887-4801

Fax 570-887-5830

Treatment Number: 13

Referring Physician: Michael Gorsline

Primary Diagnosis:

	ICD-9	ICD-10
	CM	CM
1. Plantar fascial fibromatosis	728.71	M72.2

Time In: 1204

Time Out: 1220

Total Session Minutes: 16

Pain at Start of Care: 0/10

Pain at End of Care: 0/10

Subjective Comments:

Walking pain 0/10

Feels 95% better

Interventions:

Exercise #1

Exercise Name: Plantar fascia stretch

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Brown, Jennifer Lyn

PAGE: 5 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/1/2019, D/C: 2/1/2019

02/01/2019 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)**Exercise #2**

Exercise Name: Standing wall push calf stretch with inv

Exercise #3

Exercise Name: educated: 1st step pain control, no barefoot, frozen water massage, pain control walking

Exercise #4

Exercise Name: Educated healthy eating and wt loss activity 150 minutes/wk of endurance and strength training

Details: understood

Normal gait pattern pain free

Assessment: We evaluated Mrs. Brown in PT 9/12/18 and have seen her 13 tx, 2nd to L Plantar fasciitis. Today she feels 95% better, and does not have any pain walking since she restarted HEP. She is IND with pt education and HEP for foot. We also educated on wt loss: healthy eating and activity plan. All goals met, she feels able to self manage > therefore we will d/c her PT services.

Short Goals: (2-4 wks)

- 1) IND education -- MET
- 2) IND 1st step pain control -- MET
- 3) decrease pain 25% end of day -- MET

Long Term Goals: (2-3 months)

- 1) Decrease pain 50% end of day -- MET
- 2) Intermittent pain walking -- MET
- 3) increase functional status 24 points per FOTO survey -- MET
- 4) resume walking dog pain limited -- MET

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 16****Total Treatment Minutes: 16**

Author: Michael Fritzen, PT 2/1/2019 12:24

Electronically signed by Fritzen, Michael, PT at 2/1/2019 12:25 PM



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 2/7/2019, D/C: 2/7/2019

02/07/2019 - XR GENERAL in Robert Packer XR

Imaging**Imaging****XR ELBOW 2 VIEWS RIGHT [154399047] (Final result)****XR ELBOW 2 VIEWS RIGHT [154399047]**

Resulted: 02/11/19 1612 Result status: Final result

Ordering provider: Tompkins, Nancy, NP 02/07/19 1530

Order status: Completed

Resulted by: Stuelke, Satre, MD

Filed by: Interface, Rad Results 02/11/19 1615

Performed: 02/07/19 1536 - 02/07/19 1541

Accession number: 5669580

Narrative:

Procedure(s): XR ELBOW 2 VIEWS RIGHT

Date of service: 2/7/2019 3:36 PM

Provided clinical information: 42 years, Female, "pain"

Procedure and materials: 2 images of the right elbow were obtained.

Comparison studies: None.

Observations:

No fracture. Joint spacing and alignment are anatomic. There are no significant soft tissue abnormalities.

Impression:

Impression:

Unremarkable exam.

Signed by Satre Stuelke, MD, MFA on 2/11/2019 4:12 PM

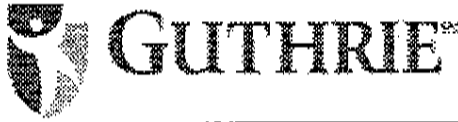
Acknowledged by: Tompkins, Nancy, NP on 02/13/19 0817

Indications

Arthralgia of right upper arm [M25.521 (ICD-10-CM)]

All Reviewers List

Tompkins, Nancy, NP on 2/13/2019 8:17 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 3/29/2019

03/29/2019 - Telephone in Sayre Family Practice

Documents

Neurodiagnostic Lab - Scan on 5/2/2019 5:56 AM by Decker-Crippen, Brenda: PAP Titration Report - RPH

Scan (below)

B#: 3642190
Physician: GILLAN

Guthrie Sleep Disorders Center Robert Packer Hospital 1 Guthrie Square ■ Sayre, PA 16840 (570)-887-4639

PAP TITRATION REPORT

Patient name:	BROWN, JENNIFER	Acq. #:	1001319
GHS MRN:	3612198	Type:	PAP
Sex:	F	Started:	4/28/2018 at 8:41:14 PM
Birth date:	10/25/1975	Stopped:	4/29/2019 at 5:26:26 AM
Age:	42 years	Duration:	8:45:12 (525.2 min)
Height:	71.0	Weight:	298.0
BMI:	38.8 kg/m2	Epworth Score:	4 / 24
Referring Physician:	Gillan, D.O., Michael	Ordering Physician:	GILLAN, DO, MICHAEL
Interpreting Physician:	Dr. Han Suk Koh	Scoring Tech:	Yvonne Tighe, RPSGT
		Acquiring Tech:	Yvonne Tighe, RPSGT

This multi-channel overnight study consists of a combination of the following: frontal, central and occipital EEG, electrooculogram (EOG), submentalis EMG (chin), anterior tibialis EMG, body position and electrocardiogram. Additional parameters monitored include: belts using ZRIP technology for thoracic and abdominal effort, airflow measured via nasal pressure transducer and nasal/oral thermistor, pulse oximetry for SPO2, one channel for snoring, and digital video recording. The tracing was scored using 30 second epochs. Hypopneas were scored per AASM definition 1B with 4% desaturations.

DEFINITIONS:

Apnea: cessation of inspiratory airflow for ten seconds or longer.

Hypopnea: reduction in airflow by 30% followed by a desaturation \geq 4%.

Central: cessation of inspiratory airflow and respiratory effort for ten seconds or longer.

Obstructive: cessation of inspiratory airflow with continued respiratory effort for ten seconds or longer.

INTERPRETATION

PAP Titration Shows:

Respiratory: Gradual CPAP titration with good AHI reduction to 4.8/h at 10 cm of water pressure. Patient tolerated the procedure well.

Oximetry: Baseline was 96% and maximal desaturation was 85% associated with sleep apneas.

Leg movements: 29 episodes with index of 4.2/hr.

EEG data: 89.6% sleep efficiency with prominent stage 2 sleep.

EKG data: SR

CONCLUSION:

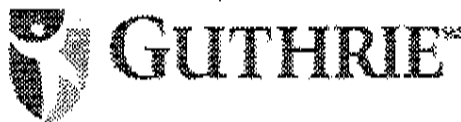
Good response to CPAP was noted.

Patient came with Epworth Sleepiness Score of 4 points and snoring history at home. Light snoring was noted in this study. Patient underwent Polysomnography in March 2018 revealing mild degree obstructive sleep apnea with AHI of 10.3/h and 84% of desaturation. Patient went to REM stage of sleep and delta wave sleep in this study. Sleep efficiency was 89.6% with sleep onset latency of 12.8 minutes reflecting possible insomnia or first night effect. No oxygen was required. 3 episodes of central apnea were noted. No periodic breathing or cardiac arrhythmia was noted. No periodic limb movement disorder was noted. CPAP titration was initiated at 4 cm and gradually increased to 11 cm with good tolerance of patient. Good AHI reduction was noted at the 10 cm. No snoring was noted at the 10 cm. REM stage of sleep and supine position were noted at the 10 cm.

Consider CPAP at 10 cm of water pressure with heated humidifier, weight reduction program, and good sleep hygiene.

This report contains critical information. Please cc: report to referring provider

Dr. Han Suk Koh
AASM Diplomate in Sleep Medicine
ABMS Diplomate in Sleep Medicine



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

03/29/2019 - Telephone in Sayre Family Practice (continued)

Documents (continued)

BR: 3612198

Physician: GILLAN

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 18840

(570)-887-4639

CPAP INFORMATION

Unit:	Ominlab	Mask Size:	Medium	C-Flex:	Plus 2
Chin Strap:	None	Mask Type:	Amara View FPM		
Humidifier:	Heated	Tolerance:	Well	Oxygen:	None

SLEEP ARCHITECTURE

Recording time	525.2 min	WASO	34.0 min
Total Sleep Time (minutes):	411.0	Light off (LO)	9:19:56 PM
Sleep Efficiency %:	93.6	Light on (LON)	4:58:44 AM

Distribution	From Light off (min)	duration	TST%
Sleep onset	12.8		
N1	12.8	48.0	11.7
N2	48.3	175.5	42.7
N3	68.5	71.0	17.3
REM	257.8	116.5	28.3

RESPIRATORY EVENT SUMMARY

Apnea-Hypopnea Index (average number of apneas and hypopneas per hour of actual recorded sleep)

	Total	REM	NREM	Supine	Rt Side	Lt Side
AHI	2.5	8.7	0.8	4.5	0.8	
Time in Min	411.0	116.5	294.5	195.2	248.6	
RDI	9.6	9.8	9.8			

RESPIRATORY EVENT SUMMARY

	CA	OA	MA	Sum Ap	HYP	A + H Events	REPA	Resp. Events
Number	3	1	0	4	13	17	49	85
Index (AHI TST)	0.4	0.1	0.0	0.6	1.9	2.5	7.2	9.6

CHEYNE STOKES RESPIRATIONS

Cheyne Stokes Breathing

None



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

03/29/2019 Telephone in Sayre Family Practice (continued)

Documents (continued)

B#: 3612196
Physician: GILLAN

Guthrie Sleep Disorders Center

Robert Packer Hospital

1 Guthrie Square • Sayre, PA 18840

(570)-857-4639

OXIMETRY DATA

Ave. O2 while awake	98	Approximate minimum O2 Value:	85
# Episodes (≥ 5.0 minutes) $SpO_2 < 88\%$	0		
Desat Index (#/hour)	0.0	WK	REM
		0.0	12.4
			NREM
			0.0

Total number of PLM episodes	14
PLM Index (/h)	0.6
PLM Arousal Index	1+
Total number of Leg movements	29
Leg Movement Index	4.2
Number of arousals associated with leg movements	0

AROUSAL SUMMARY

Total number Arousals : 67
Arousal Index : 15.6/h (sleep)

CARDIAC SUMMARY

Average Heart Rate During Sleep:	80.5 bpm
Highest Heart Rate During Sleep:	107 bpm
Highest Heart Rate During Recording (TIB):	116 bpm

CARDIAC EVENT OBSERVATIONS

TYPE	YES	NO	RATE / DURATION
Bradycardia:		✓	Lowest HR Scored: N/A
Unclassified Tachycardia:		✓	Highest HR Scored: N/A
Sinus Tachycardia During Sleep:		✓	Highest HR Scored: N/A
Narrow Complex Tachycardia:		✓	Highest HR Scored: N/A
Wide Complex Tachycardia:		✓	Highest HR Scored: N/A
Asystole:		✓	Longest Pause: N/A
Atrial Fibrillation:		✓	Duration Longest Event: N/A



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Visit date: 3/29/2019

EXHIBIT NO. B14F

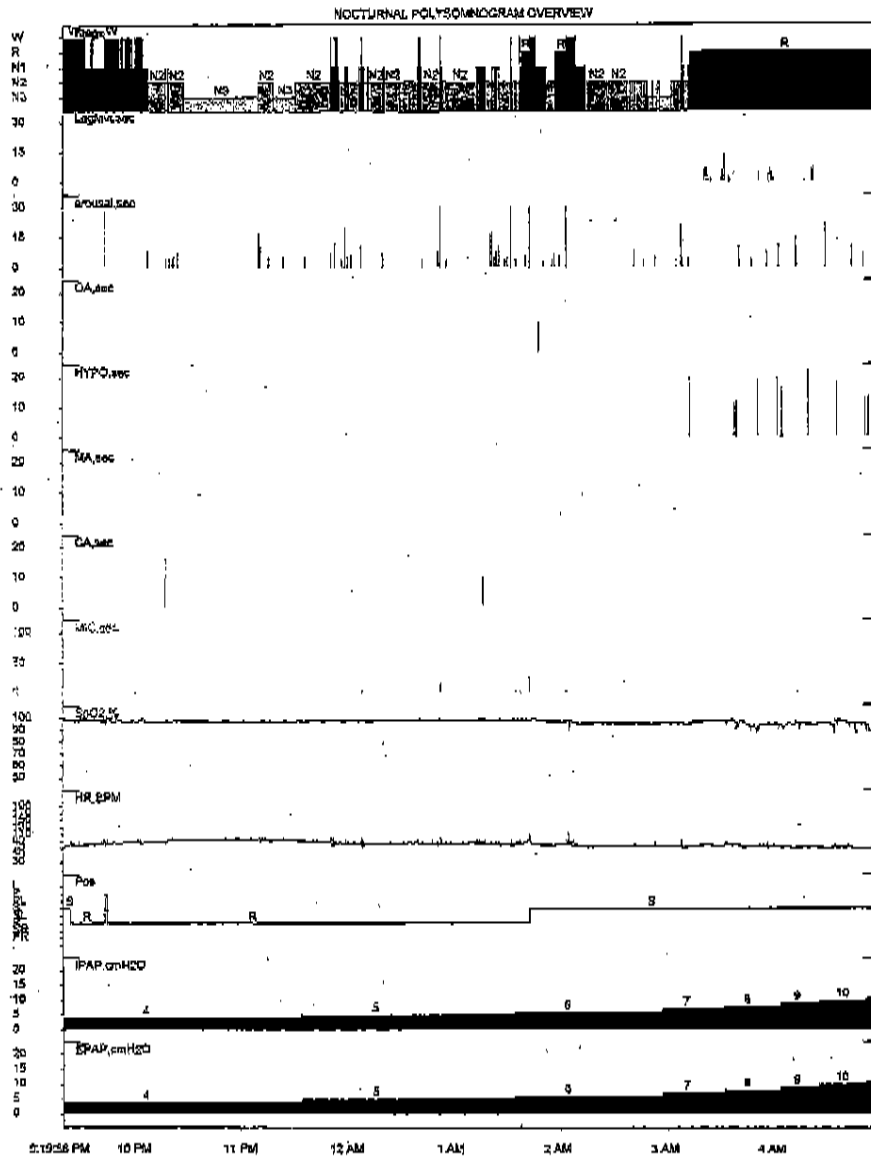
PAGE: 10 OF 76

03/29/2019 Telephone in Sayre Family Practice (continued)

Documents (continued)

B#: 3612198
Physician: GILLAN

Guthrie Sleep Disorders Center
Robert Packer Hospital
1 Guthrie Square ■ Sayre, PA 18840
(570)-887-4639





Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Visit date: 3/29/2019

03/29/2019 Telephone in Sayre Family Practice (continued)

Documents (continued)

B#: 3612198
Physician: GILLAN

Guthrie Sleep Disorders Center
Robert Packer Hospital
 1 Guthrie Square • Sayre, PA 18840
 (570)-837-4639

PAP PRESSURE DISTRIBUTION:

IPAP	EPAP	TIB (min)	Sleep (min)	REM (min)	Apnea				Hypopnea		RERAs		AHI	RDI	Minimum SpO2
					CA#	OA#	MA#	Index	#	Index	#	Index			
4	4	121.3	101.8	0.0	2	0	0	1.2	0	0.0	9	5.3	1.2	6.5	95
5	5	119.6	115.1	0.0	1	0	0	0.5	0	0.0	27	14.1	0.5	14.6	95
6	6	82.2	72.7	10.5	0	1	0	0.8	0	0.0	9	7.4	0.8	8.3	93
7	7	34.6	34.1	19.6	0	0	0	0.0	1	1.8	2	3.5	1.8	3.3	86
8	8	31.2	31.2	31.2	0	0	0	0.0	5	9.6	0	0.0	9.6	9.6	87
9	9	21.5	21.5	21.5	0	0	0	0.0	3	8.4	1	2.8	8.4	11.2	88
10	10	26.3	26.3	26.3	0	0	0	0.0	2	4.6	1	2.3	4.6	6.8	85
11	11	6.1	6.1	6.1	0	0	0	0.0	2	19.7	0	0.0	19.7	19.7	86



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

04/18/2019 - ED in RPH Emergency Department

ED Provider Note

ED Provider Notes by Kniess, Carol Katherine, DO at 4/18/2019 3:07 PM

Author: Kniess, Carol Katherine, DO

Service: EMERGENCY MEDICINE

Author Type: Locum

Filed: 4/18/2019 5:17 PM

Date of Service: 4/18/2019 3:07 PM

Status: Signed

Editor: Kniess, Carol Katherine, DO (Locum)

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DATE OF SERVICE: 4/18/2019

LOCATION: RPH EMERGENCY DEPARTMENT

History of Present Illness

Chief Complaint

Patient presents with

- Headache

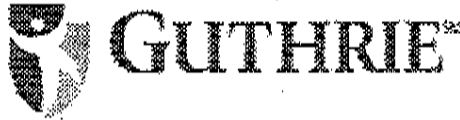
HPI

42 yo woman who presents to ED with typical headache that starts with neck pain and spreads to the occipital area and then the vertex of the head, and to the left frontal area above the left eye/orbit. No photophobia, neck stiffness, recent trauma. Symptoms have been intermittent for years and today's symptoms are typical. She was seen by Guthrie physician yesterday and had injections for pain at her neck, which she has had before. States this usually resolves neck and head pain, but just resolved neck pain, though headache still present. Usually helps with headache too. Not worst headache of life. Not sudden in onset. Started gradually and insidiously 8 days ago. Undergoing a lot of stress with caring for family members and working. No vision changes, photophobia, floaters, halos, blurry vision, nausea, vomiting, fever, chills, sweats, stiff neck, abdominal/chest/back pain, leg pain or weakness, arm pain or weakness. No speech or swallowing problems. Had brief episodes of twitching in the area of her forehead above the left supraorbital ridge, lasting a few seconds, occurring a few times but are not present now. She states family practice wanted her to have a CT scan. Patient states she is walking and balancing ok. Feels she has been having memory issues over the last several months, becoming forgetful, but working and caring for family, and feels this has been fatiguing. No face pain, nasal congestion. Has been prescribed multiple different medication for her pain, and declines pain medication at this time. No dizziness or lightheadedness.

Patient Active Problem List

Diagnosis

- Plantar fascial fibromatosis
- Unspecified sinusitis (chronic)
- HTN (hypertension), benign
- GERD (Gastroesophageal Reflux Disease)
- Rheumatoid arthritis (HCC)
- Hyperhidrosis disorder
- Obesity
- GAD (generalized anxiety disorder)
- Nontoxic multinodular goiter
- ADHD (attention deficit hyperactivity disorder)
- Severe obstructive sleep apnea



Brown, Jennifer Lyn

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Adm: 4/18/2019, D/C: 4/18/2019

04/18/2019 ED in RPH Emergency Department (continued)

ED Provider Note (continued)

- Environmental allergies
- Depression
- Fibromyalgia
- Status post bariatric surgery
- Tremor of left hand
- Benign head tremor
- Crohn's disease (HCC)
- Multiple benign nevi
- Cherry angioma
- Sun-damaged skin
- Neuritis
- Drug eruption
- Rash
- Long term current use of immunosuppressive drug
- Vitamin D deficiency
- Vitamin B12 deficiency
- Therapeutic drug monitoring
- Myopia of both eyes
- Bilateral dry eyes
- Pain in joint, upper arm
- Impingement syndrome of left shoulder

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	
• Multinodular goiter	
• Nontoxic multinodular goiter	1/18/2011
• Obesity	
• Persistent mental disorders due to conditions classified elsewhere	
• Physiological ovarian cysts	10/7/2008

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 4/18/2019, D/C: 4/18/2019

EXHIBIT NO. B14F

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04/18/2019 - ED in RPH Emergency Department (continued)

ED Provider Note (continued)

- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
<i>Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY	N/A	6/2/2017
<i>Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY	N/A	6/11/2018
<i>Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</i>		
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD	N/A	8/13/2014
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;</i>		
• EGD	N/A	6/24/2016
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD	N/A	6/2/2017
<i>Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD	N/A	6/11/2018
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</i>		
• EGD (GUTHRIE / NON GUTHRIE)		
• LAPAROSCOPIC CHOLECYSTECTOMY		2013
<i>with liver biopsy</i>		
• PR CLOSED RX TARSAL FX,EACH		
• PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY		12/10/2014
<i>for obesity - Dr. Alley - RPH</i>		
• PR REMOVAL GALLBLADDER		
• TONSILLECTOMY		11/26/07

Family History

Problem	Relation	Age of Onset
• Diabetes	Mother	
• Heart	Mother	
• Hypertension	Mother	
• Psychiatry	Mother	
<i>Anxiety</i>		
• Arthritis	Mother	
• Heart Disease	Mother	
• Kidney Disease	Mother	
• Diabetes	Father	
• Hypertension	Father	
• Genetic	Father	
<i>Marfan syndrome</i>		

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 4/18/2019, D/C: 4/18/2019

EXHIBIT NO. B14F

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04/18/2019 - ED in RPH Emergency Department (continued)

ED Provider Note (continued)

- | | |
|--------------------------------------|----------------------|
| • Heart | Father |
| ?Marfan's Syndrome | |
| • Clotting Disorder | Father |
| • Heart Disease | Father |
| • Heart | Paternal Uncle |
| Aortic Dissection, Marfan's Syndrome | |
| • Heart Disease | Paternal Uncle |
| • Diabetes | Maternal Grandfather |
| • Thyroid Disease | Maternal Grandfather |
| • Macular Degeneration | Paternal Grandmother |
| • Psychiatry | Maternal Aunt |
| ADHD | |
| • Genetic | Maternal Aunt |
| Marfan syndrome | |
| • Psychiatry | Other |
| ADHD | |
| • Cancer | Paternal Grandfather |
| • Glaucoma | No family history |
| • Blindness | No family history |
| • Other Eye Problems | No family history |
| • Anesth Problems | No family history |

Social History

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics

- Alcohol use: No
- Alcohol/week: 0.0 oz
- Drug use: No

Current Facility-Administered Medications

Medication

- saline (OCEAN) nasal spray 0.65 %

Current Outpatient Medications

Medication

Sig

- | | |
|--|--|
| • buPROPion (WELLBUTRIN XL)
300 MG Oral TABLET SR 24 HR | Take 1 Tab by mouth DAILY. |
| • calcium carbonate (CALTRATE)
600 MG Oral Tab | Take 1 Tab by mouth TWICE DAILY. |
| • Cholecalciferol (VITAMIN D3)
1000 units Oral Cap | Take 1 Cap by mouth DAILY. |
| • cyanocobalamin (VITAMIN B12)
1000 MCG/ML Injection Solution | Inject 1 mL within a muscle EVERY THIRTY DAYS for 12 doses. |
| • cyclobenzaprine (FLEXERIL) 10
MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS
NEEDED for muscle spasm. |
| • EPINEPHrine 0.3 MG/0.3ML
Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). |
| • ergocalciferol (DRISDOL,
CALCIFEROL, VITAMIN D) 50000 | Take 1 Cap by mouth EVERY 7 DAYS. Take times 8
weeks. |

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Brown, Jennifer Lyn
 MRN: 340616, DOB: 10/26/1976, Sex: F
 Adm: 4/18/2019, D/C: 4/18/2019

EXHIBIT NO. B14F

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04/18/2019 ED in RPH Emergency Department (continued)

ED Provider Note (continued)

units Oral Cap	
• fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension	Spray 2 Sprays in nose DAILY.
• folic acid 1 MG Oral Tab	Take 1 Tab by mouth DAILY.
• Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc	1 Each by Does not apply route EVERY 7 DAYS.
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate
• Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc	Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly
• levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab	Take 1 Tab by mouth DAILY.
• lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab	Take 1 Tab by mouth DAILY.
• loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab	Take 1 Tab by mouth DAILY.
• methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution	Inject 1 mL beneath the skin EVERY SATURDAY.
• Nitroglycerin 0.4 % Rectal Ointment	Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.
• ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm
• sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC	Take 2 Tabs by mouth TWICE DAILY.
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days
• Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.
• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Review of Systems

Negative except per HPI above. All systems reviewed.

Physical Exam

Temp: 98 °F (36.7 °C) (04/18/19 1416)

Pulse: 88 (04/18/19 1416)

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

04/18/2019 - ED in RPH Emergency Department (continued)

ED Provider Note (continued)

Resp: 18 (04/18/19 1416)

BP: 149/77 (04/18/19 1416)

SpO2: 96 % (04/18/19 1416)

Physical Exam

Constitutional	No acute distress. Well appearing.
HEENT	Normocephalic. Atraumatic. No temporal artery tenderness. PERRL. EOMI. Cornea clear. Sclera white. Visual fields full to confrontation. Moist mucous membranes
Neck	Supple. Full, pain-free AROM. No meningismus.
Cardiovascular	Regular rate. Regular rhythm. No UE/LE swelling or tenderness
Pulmonary	Normal effort. No respiratory distress.
Abdominal	Soft. No tenderness, distention, rebound, rigidity, or guarding.
Genitourinary	Deferred
Back	No focal tenderness
Musculoskeletal	Moves all extremities spontaneously.
Neurological	Level of Consciousness: Awake and alert. Not drowsy. Not lethargic. Not unresponsive. Orientation: Oriented to person, place and time Cranial Nerves: CNs II-XII are intact. No diplopia. No nystagmus. Motor: Bilateral UE/LE MMT is 5/5. No abnormal tone. No clonus. No tremor. Sensation: Gross LT/PP sensation of Face/UE/LE is intact. Speech: No dysarthria. No aphasia. Coordination: Finger to nose intact. Heel to shin intact. Gait: steady without device, including standard gait and heel to toe gait. Normal unilateral balance.
Skin	Warm. Dry. No rash, petechiae, or purpura. No external signs of trauma.
Psychiatric	Cooperative.

ED Course

Procedures

Critical Care Time: Critical Care < 30 minutes excluding billable procedures.

Patient Progress: stable.

Vitals:

Temp: 98 °F (36.7 °C) (04/18/19 1416)

Pulse: 88 (04/18/19 1416)

Resp: 18 (04/18/19 1416)

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EXHIBIT NO. B14F
PAGE: 18 OF 76
Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 4/18/2019, D/C: 4/18/2019

04/18/2019 - ED in RPH Emergency Department (continued)

ED Provider Note (continued)

BP: 149/77 (04/18/19 1416)
SpO2: 96 % (04/18/19 1416)

Assessment / Impression

1. Encounter for medical screening examination
2. Headache syndrome

Normal neuro exam
Chronic headache syndrome
Typical pain onset, location, character, quality
CT head requested by family practice
CT head shows no acute findings
Do not suspect meningitis, temporal arteritis, subarachnoid hemorrhage, optic neuritis, or other acute emergent disorder
Saw Dr. Attia yesterday for trigger point injection for chronic neck and head pain

Plan

Discharge home with PCP follow up
Continue working with pain management/Dr. Attia for trigger point therapy and pain management
May benefit from neurology evaluation if headaches become intractable

Electronically signed by Kniess, Carol Katherine, DO at 4/18/2019 5:17 PM

Imaging

Imaging

CT HEAD WITHOUT IV CONTRAST [157252875] (Final result)

CT HEAD WITHOUT IV CONTRAST [157252875]

Resulted: 04/18/19 1552, Result status: Final result

Ordering provider: Kniess, Carol Katherine, DO 04/18/19 1518

Order status: Completed

Resulted by: Zwirko, Richard, MD

Filed by: Interface, Rad Results 04/18/19 1554

Performed: 04/18/19 1529 - 04/18/19 1545

Accession number: 5745877

Narrative:

Procedure(s): CT HEAD WITHOUT IV CONTRAST

Date of service: 4/18/2019 3:29 PM

Provided clinical information: 42 years, Female, "Headache, acute, norm neuro exam: sent by family practice for CT"

Procedure and materials: Standard protocol.

Contrast: None.

Comparison studies: 7/17/2008.

Observations:

There is no midline shift or mass effect. CSF spaces appear normal for age. No pathologic fluid collections are seen. No acute intracranial hemorrhage is noted.

The gray-white matter differentiation is well preserved. There is no evidence for an acute transcortical or vascular territorial infarct.



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 4/18/2019, D/C: 4/18/2019

04/18/2019 - ED in RPH Emergency Department (continued)

Imaging (continued)

There is no depressed calvarial fracture. The skull base and surrounding soft tissues appear unremarkable.

Impression:

IMPRESSION:

No acute intracranial findings.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Signed by Richard Zwirko, MD on 4/18/2019 3:52 PM

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019



05/24/2019 Admission (Discharged) in RPH RECOVERY

H&P Notes

Interval H&P Note by Choi, Joseph, MD at 5/24/2019 7:33 AM

Author: Choi, Joseph, MD

Service: ORTHOPEDIC

Author Type: Physician

Filed: 5/24/2019 7:33 AM

Date of Service: 5/24/2019 7:33 AM

Status: Signed

Editor: Choi, Joseph, MD (Physician)

I have reviewed the H&P and examined the patient. No changes have occurred unless otherwise indicated. Joseph Choi, MD 5/24/2019

Electronically signed by Choi, Joseph, MD at 5/24/2019 7:33 AM

Source Note

Author: Choi, Joseph, MD

Service: —

Author Type: Physician

Filed: 5/8/2019 8:56 AM

Date of Service: 5/6/2019 11:30 AM

Status: Signed

Editor: Choi, Joseph, MD (Physician)

GUTHRIE SP/OP BRIEF H&P

1 GUTHRIE SQUARE
SAYRE PA 18840-1625
570-888-5858

PATIENT: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

DOS: See records

Chief Complaint:left shoulder pain

Past History:see records

Surgery:left shoulder subacromial decompression, distal clavicle excision

Allergies/Reaction:See records

Medications:

Outpatient Medications Marked as Taking for the 5/6/19 encounter
(Office Visit) with Choi, Joseph, MD

Medication	Sig	Dispense	Refill
• buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR	Take 1 Tab by mouth DAILY.	90 Tab	1
• calcium carbonate (CALTRATE) 600 MG Oral Tab	Take 1 Tab by mouth TWICE DAILY.	60 Tab	5
• Cholecalciferol (VITAMIN	Take 1 Cap by	90 Cap	3



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)

H&P Notes (continued)

- | | | | |
|--|---|----------|---|
| D3) 1000 units Oral Cap | mouth DAILY. | | |
| • cyanocobalamin (VITAMIN B12) 1000 MCG/ML Injection Solution | Inject 1 mL within a 12 mL muscle EVERY THIRTY DAYS for 12 doses. | 0 | |
| • cyclobenzaprine (FLEXERIL) 10 MG Oral Tab | Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm. | 42 Tab | 0 |
| • EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector | 0.3 mg by Injection route AS NEEDED (bee sting). | 1 Each | 3 |
| • ergocalciferol (DRISDOL, CALCIFEROL, VITAMIN D) 50000 units Oral Cap | Take 1 Cap by mouth EVERY 7 DAYS. Take times 8 weeks. | 8 Cap | 1 |
| • fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension | Spray 2 Sprays in nose DAILY. | 1 Bottle | 0 |
| • folic acid 1 MG Oral Tab | Take 1 Tab by mouth DAILY. | 30 Tab | 5 |
| • Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc | 1 Each by Does not apply route EVERY 7 DAYS. | 100 Each | 0 |
| • Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc | 25 mg by Does not apply route EVERY 7 DAYS. Use weekly for methotrexate | 100 Each | 1 |
| • Insulin Syringe-Needle U-100 31G X 3/8" 0.5 ML Does not apply Misc | Inject 1 mL beneath the skin EVERY 7 DAYS. Use with methotrexate weekly | 100 Each | 0 |
| • levonorgestrel-ethinyl estradiol triphasic (LEVONEST) Oral Tab | Take 1 Tab by mouth DAILY. | 84 Tab | 3 |
| • lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab | Take 1 Tab by mouth DAILY. | 90 Tab | 1 |
| • loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab | Take 1 Tab by mouth DAILY. | 30 Tab | 0 |
| • methotrexate sodium, PF, (MTX) 50 MG/2ML Injection | Inject 1 mL beneath the skin | 12 mL | 1 |



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 5/24/2019, D/C: 5/24/2019

EXHIBIT NO. B14F

PAGE: 22 OF 76

05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)

H&P Notes (continued)

Solution	EVERY SATURDAY.		
• Nitroglycerin 0.4 % Rectal Ointment	Place 1 Appl per rectum TWICE DAILY. Apply with cotton applicator.	1 Tube	0
• ondansetron (ZOFran ODT) 8 MG Oral TABLET DISPERSIBLE	Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea.	30 Tab	1
• pantoprazole (PROTONIX) 40 MG Oral Tab EC	Take 1 Tab by mouth DAILY.	90 Tab	1
• Probiotic Product (VSL#3) Oral Cap	Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm	60 Cap	3
• [DISCONTINUED] sulfasalazine (AZULFIDINE EN-TABS) 500 MG Oral Tab EC	Take 2 Tabs by mouth TWICE DAILY.	120 Tab	3
• Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc	Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days	12 Each	0
• Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe	Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks.	1 Syringe	5
• venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1
• venlafaxine (EFFEXOR XR) 75 MG Oral CAPSULE SR 24 HR	Take 1 Cap by mouth DAILY.	90 Cap	1

Current Facility-Administered Medications for the 5/6/19 encounter (Office Visit) with Choi, Joseph, MD

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• saline (OCEAN) nasal spray 0.65 %	2 Spray	Nasal	Q2H PRN	Braslow, Matthew Lim, DO		

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)

H&P Notes (continued)

PHYSICAL EXAM:

Vital Signs on nurses notes, and patient stable

Skin intact

Neurovascularly intact

Lungs: CTA bilateral

CV: RRR

Plan: Proceed with scheduled procedure. Risks include but not limited to bleeding, infection, nerve damage, compartment syndrome, wound healing problems, blood clots, lung clots, loss of limb, fracture, death, need for further surgery, hardware complications and anesthetic complications. Benefits are decreased pain.

Author: Joseph Choi, MD 5/8/2019

Electronically signed by Choi, Joseph, MD at 5/8/2019 8:56 AM

OP Notes

Op Note by Choi, Joseph, MD at 5/24/2019 9:25 AM

Author: Choi, Joseph, MD

Service: ORTHOPEDIC

Author Type: Physician

Filed: 5/24/2019 9:30 AM

Date of Service: 5/24/2019 9:25 AM

Status: Signed

Editor: Choi, Joseph, MD (Physician)

OPERATIVE NOTE

RPH/Guthrie Clinic

Sayre PA

Name: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

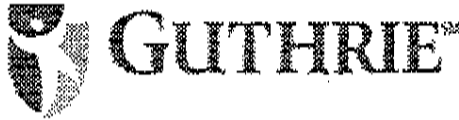
Date of procedure: 5/24/19

Preoperative diagnosis:

1. Impingement syndrome and acromioclavicular joint arthritis-left

Postoperative diagnosis: Same

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 5/24/2019, D/C: 5/24/2019
PAGE: 24 OF 76

05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)

OP Notes (continued)

Procedure:

1. Arthroscopic subacromial decompression with acromioplasty and distal clavicle excision-left

Attending: Joseph Choi, MD, PhD

Assistant: Nick Marsiglio, PA. Due to the complicated nature of this case an assistant was necessary. His/her help was invaluable to the completion of this case.

Implants:

None

Tubes/Drains: none

Estimated Blood Loss: minimal

Antibiotics: See records

Anesthesia:

1. General endotracheal anesthesia
2. Interscalene block

Complications: none

Sponge and needle counts: correct

Indications for procedure:

Having failed conservative care, this patient opted for operative intervention. The risks and benefits are discussed in my pre operative history and physical. Informed consent was obtained. Medical clearance was obtained if necessary.

Procedure:

The patient was identified in the waiting area. The left shoulder was marked, and the consent form and history/physical was reviewed. This was consistent with what we planned on doing. The anesthesia staff administered antibiotics and an interscalene block. Afterwards the patient was brought to the operating room where a second time out was done consistent with hospital protocol. After general anesthesia was administered, the patient was placed in a T-Max head holder in the beach chair position. All prominences were well padded. Range of motion was normal. There was no instability. After prepping and draping the shoulder, a standard posterior portal was placed and a diagnostic arthroscopy was performed. The glenoid cartilage was intact. The humeral head cartilage was intact. The biceps tendon was intact. The labrum was intact. The visualized articular portion of the rotator cuff was intact. The subscapularis was intact. An extensive intra articular debridement was not needed. After the intra articular part was completed, the camera was placed into the subacromial space and a lateral portal was established using a spinal needle as a guide. I placed the camera from the side and from the back, through a 7 mm screw-in cannula, I did a thorough subacromial decompression. Extensive bursitis was present. I also partially resected the undersurface of the coracoacromial ligament and exposed a small but prominent spur on the undersurface of the acromion. This was removed with a burr in reverse. After the acromioplasty was performed,

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019



05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)

OP Notes (continued)

inspected the bursal side of the rotator cuff tendons. They were intact. No tear was present. I established an anterior portal with an aid of a spinal needle for the distal clavicle resection. Soft tissue was cleared underneath as well as in the acromioclavicular joint. Debris was removed with a shaver. Using a burr I removed lateral clavicle as well as bone from the acromial side. The distal clavicle excision was uniformed when viewed with the 70 degree as well as the 30 degree arthroscope. We had enough room in the acromioclavicular joint-approximately 8 mm of space. There is no abutment with cross adduction testing. Afterwards, the arthroscopy was terminated, and the wounds were closed. Bulky dressing was applied and a sling was placed. The patient was brought to the recovery room in good condition.

Postoperative course:

Patient will be in a sling for comfort. Activity as tolerated. Pain medication as prescribed. My standard discharge sheet was given to the patient.

Electronically signed by Choi, Joseph, MD at 5/24/2019 9:30 AM

Discharge Summary Note

Discharge Summary by Marsiglio, Nicolas, RPA-C at 5/24/2019 11:25 AM

Author: Marsiglio, Nicolas, RPA-C

Service: ORTHOPEDIC

Author Type: Physician Assistant

Filed: 5/27/2019 8:28 AM

Date of Service: 5/24/2019 11:25 AM

Status: Signed

Editor: Marsiglio, Nicolas, RPA-C (Physician Assistant)

Cosigner: Choi, Joseph, MD at 5/28/2019

4:17 PM

GUTHRIE SP/OP DISCHARGE NOTE

Robert Packer Hospital

1 GUTHRIE SQUARE

SAYRE PA 18840

570-888-6666

PATIENT: Jennifer Lyn Brown

SURGEON: Primary: Choi, Joseph, MD

ASSISTING: Nicolas Marsiglio, RPA-C

MRN: 340616

DOB: 10/26/1976

DATE OF SURGERY: 5/24/2019

Procedure: left shoulder arthroscopy, distal clavicle excision

Principle Diagnosis: impingement syndrome and acromioclavicular joint arthritis - left

Associated Condition(s): Same as pre-op, unless otherwise indicated

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Brown, Jennifer Lyn

PAGE: 26 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/24/2019, D/C: 5/24/2019

05/24/2019 - Admission (Discharged) in RPH RECOVERY (continued)**Discharge Summary Note (continued)****Mental Status:** Same as pre-op, unless otherwise indicated.**Condition:** Stable, unless otherwise indicated**Disposition of Care:** Discharge to home.**Appointment with/ or Follow-up with Dr. Joseph Choi** 2 weeks.

No orders of the defined types were placed in this encounter.

Other Comments: see discharge instructions**Author:** Nicolas Marsiglio, RPA-C 5/27/2019

Electronically signed by Marsiglio, Nicolas, RPA-C at 5/27/2019 8:28 AM

Electronically signed by Choi, Joseph, MD at 5/28/2019 4:17 PM



GUTHRIE

Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/21/2019, D/C: 6/21/2019

06/21/2019 - MR ABDOMEN PELVIS ENTEROGRAPHY in Robert Packer MR

Imaging

Imaging

MR ABDOMEN PELVIS ENTEROGRAPHY [159007929] (Final result)

MR ABDOMEN PELVIS ENTEROGRAPHY [159007929]

Resulted: 06/27/19 1143, Result status: Final result

Ordering provider: Georgetson, Michael J, MD FACG

Order status: Completed

06/21/19 1041

Resulted by: Bennett, Christopher J, MD

Filed by: Interface, Rad Results 06/27/19 1145

Performed: 06/21/19 1204 - 06/21/19 1340

Accession number: 5793159

Narrative:

Procedure: MR ABDOMEN PELVIS ENTEROGRAPHY.

Date of Service: 6/21/2019 12:04 PM.

Relevant Clinical Information: Abdominal pain, unspecified; Crohn dz, known, increasing abd pain or fever or leukocytosis.

Procedure and Materials: MR enterography

Comparison Studies: 10 mL Gadavist IV

Observations:

The small bowel and colon are normal in caliber. No mural thickening or hyperenhancement is identified to indicate active enteritis. No stricture or fistulization is apparent. No organized abscess is identified.

Visualized portions of the liver, spleen, kidneys and pancreas are unremarkable. The patient is status post cholecystectomy, without biliary ductal dilation.

Impression:

No evidence of active enteritis, stricture, fistulization or abscess.

Signed by Christopher Bennett, MD on 6/27/2019 11:43 AM

Acknowledged by

Georgetson, Michael J, MD FACG on 06/27/19 1721

Shaw, Beth, RN on 06/28/19 1327

Indications

Generalized abdominal pain [R10.84 (ICD-10-CM)]

Crohn's disease with complication, unspecified gastrointestinal tract location (HCC) [K50.919 (ICD-10-CM)]

All Reviewers List

Shaw, Beth, RN on 6/28/2019 1:27 PM

Georgetson, Michael J, MD FACG on 6/27/2019 5:21 PM

**GUTHRIE**

Brown, Jennifer Lyn

PAGE: 28 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/26/2019, D/C: 6/26/2019

06/26/2019 - Screening Tomo in Robert Packer MAM

Imaging**Imaging****MAMMO SCREENING TOMOSYNTHESIS BILATERAL [159007935] (Final result)****MAMMO SCREENING TOMOSYNTHESIS BILATERAL [159007935]**

Resulted: 06/27/19 1016, Result status: Final result

Ordering provider: Ripic, Shelli, CRNP 06/26/19 1617

Order status: Completed

Resulted by: Werner, Elizabeth, MD

Filed by: Interface, Rad Results 06/27/19 1019

Performed: 06/26/19 1639 - 06/26/19 1641

Accession number: 5808345

Narrative:

Procedure(s): MAMMO SCREENING TOMOSYNTHESIS BILATERAL

Date of service: 6/26/2019 4:39 PM

Provided clinical information: 42-year-old asymptomatic female for screening mammogram

Procedure and materials: Bilateral 2-D digital mammography and 3-D digital breast tomosynthesis in CC and MLO projections were obtained.

2-D images were analyzed by a CAD system.

Comparison studies: 1/25/18, 6/5/17, 11/21/16.

Most recent clinical breast exam: A year ago.

Observations:

Breast composition: b. There are scattered areas of fibroglandular density.

Mass: None.

Calcifications: None.

Architectural Distortion: None.

Asymmetries: None.

Other pertinent findings: None.

Impression:

Negative. No mammographic evidence of malignancy.

Recommend annual screening mammogram.

BI-RADS Assessment: Category 1: Negative

Management Recommendation: Routine annual screening mammography.

Signed by Elizabeth Werner, MD on 6/27/2019 10:16 AM

Acknowledged by: Ripic, Shelli, CRNP on 06/27/19 1237

Indications

Visit for screening mammogram [Z12.31 (ICD-10-CM)]

All Reviewers List

Ripic, Shelli, CRNP on 6/27/2019 12:37 PM

**GUTHRIE**

Brown, Jennifer Lyn

PAGE: 29 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 8/22/2019, D/C: 8/22/2019

08/22/2019 XR GENERAL in Robert Packer XR

Imaging**Imaging****XR ELBOW MIN 3 VIEWS LEFT (STANDARD) [162675879] (Final result)****XR ELBOW MIN 3 VIEWS LEFT (STANDARD) [162675879]**

Resulted: 08/25/19 1054, Result status: Final result

Ordering provider: Gillan, Michael F, DO 08/22/19 1453

Order status: Completed

Resulted by: Ravi, Ananth, MD

Filed by: Interface, Rad Results 08/25/19 1056

Performed: 08/22/19 1454 - 08/22/19 1500

Accession number: 5878866

Narrative:

Procedure(s): XR ELBOW MIN 3 VIEWS LEFT (STANDARD)

Date of service: 8/22/2019 2:54 PM

Provided clinical information: 42 years, Female, "elbow pain"

Procedure and materials: Standard protocol.

Comparison studies: March, 2016.

...

Impression:

No fracture. No significant joint effusion.

Signed by Ananth Ravi on 8/25/2019 10:54 AM

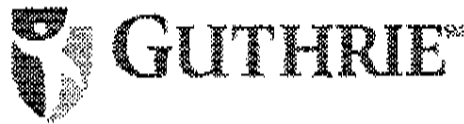
Acknowledged by: Gillan, Michael F, DO on 08/26/19 1156

Indications

Left elbow pain [M25.522 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 8/26/2019 11:56 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 9/17/2019, D/C: 9/17/2019
EXHIBIT NO. B14F
PAGE: 30 OF 76

09/17/2019 - EVALUATION in RPH Physical Therapy

Clinic Notes

Therapy Plan of Care

Traverso, Jose, DPT at 9/17/2019 11:29 AM

Author: Traverso, Jose, DPT	Service: FAMILY PRACTICE	Author Type: Physical Therapist
Filed: 9/17/2019 11:33 AM	Date of Service: 9/17/2019 11:29 AM	Status: Signed
Editor: Traverso, Jose, DPT (Physical Therapist)		Cosigner: Attia, Maximos, MD at 9/17/2019 2:01 PM

The Guthrie Clinic
Initial Evaluation Plan of Care
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Patient: Jennifer Lyn Brown
MRN: 340616
DOB: 10/26/1976
Date of Service: 9/17/2019

Referring Physician: Michael F Gillan

Plan of Care Start Date: 09/17/19

Plan of Care Expiration Date: 12/17/19

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Rehabilitative Prognosis: Guarded

Goals:

Pain: Patient will report decrease in left shoulder pain to 2/10 or less when performing overhead activities, vacuuming, left sidelying.
Posture: Patient will demonstrate good awareness of proper sitting posture without cuing from therapist.
Able to lift her dog (<20 lbs) without significant left shoulder pain

Planned Intervention(s): PT Eval Moderate Complexity (97162);Neuro Re-Education (97112);Therapeutic Exercise (Timed) (97110);Manual Therapy (Timed) (97140);Ultrasound (Timed) (97035)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

Frequency of Treatment: 1-2 times a week

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Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/17/2019, D/C: 9/17/2019

09/17/2019 - EVALUATION in RPH Physical Therapy (continued)

Clinic Notes (continued)**Duration of Treatment:** 3 months

The Physical Therapy Plan of Care has been discussed with the patient. Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under my care.

Gillan, Michael F, DO
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: Jose Traverso, DPT 9/17/2019 11:29

Electronically signed by Traverso, Jose, DPT at 9/17/2019 11:33 AM
Electronically signed by Attia, Maximos, MD at 9/17/2019 2:01 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 9/19/2019, D/C: 9/19/2019
EXHIBIT NO. B14F
PAGE: 32 OF 76

09/19/2019 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 9/19/2019 10:04 AM

Author: Traverso, Jose, DPT Service: — Author Type: Physical Therapist
Filed: 9/19/2019 10:41 AM Date of Service: 9/19/2019 10:04 AM Status: Signed
Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 2

Referring Physician: Michael F Gillan

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Time In: 1000

Time Out: 1030

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: Soreness at admission, reports ability to perform HEP without significant pain.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 3
Total Minutes (all Therapeutic Exercise): 15

Exercise #1

Exercise Name: Thoracic extension in sitting and standing position during expiration

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Brown, Jennifer Lyn

PAGE: 33 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/19/2019, D/C: 9/19/2019

09/19/2019 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Reason for Exercise: Joint Mobility

Location/Body Area: Thoracic Spine

Sets/Reps: 2x5

Exercise #2

Exercise Name: Seated Row

Reason for Exercise: Strengthening

Location/Body Area: Thoracic Spine; Shoulder

Sets/Reps: 3x10

Resistance: red TB

Exercise #3

Exercise Name: Seated shoulder flexion WAND

Reason for Exercise: Flexibility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Manual Therapy (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance. MET to promote left shoulder flexion. Left median and radial pumps/glides in supine.

Total Minutes (All Manual Therapy): 10

Unrestricted left shoulder AROM, absent significant mechanical findings.

Assessment: Patient demonstrates fair tolerance to exercise activity, fair adherence to HEP. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments including sustained physical activities involving reaching overhead, carrying groceries, house keeping.

Plan for Next Visit: Physical therapy intervention will emphasize therapeutic exercise, neuromuscular re-education, manual therapy, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 25****Total Treatment Minutes: 25**

Author: Jose Traverso, DPT 9/19/2019 10:41

Electronically signed by Traverso, Jose, DPT at 9/19/2019 10:41 AM



Brown, Jennifer Lyn

PAGE: 34 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/23/2019, D/C: 9/23/2019

09/23/2019 - FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 9/23/2019 1:40 PM

Author: Traverso, Jose, DPT

Service: —

Author Type: Physical Therapist

Filed: 9/23/2019 3:06 PM

Date of Service: 9/23/2019 1:40 PM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic

Treatment Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

Tel 570-887-4801

Fax 570-887-5830

Treatment Number: 3

Referring Physician: Michael F Gillan

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Time In: 1330

Time Out: 1400

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: At admission patient reports left elbow and shoulder pain during ADLs, taking care of her mother, playing on her phone and computer. Denies acute or constitutional symptoms. Patient reports left elbow and shoulder likely related to cleaning at home, phone and computer entertainment. No worse after today's encounter.

Interventions:

Therapeutic Exercises (97110)

Patient Education/Home Exercise Program: yes

Number of Exercises?: 3

Total Minutes (all Therapeutic Exercise): 15

1066



Brown, Jennifer Lyn

PAGE: 35 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 9/23/2019, D/C: 9/23/2019

09/23/2019 FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)**Exercise #1**

Exercise Name: Standing bilateral shoulder extension

Reason for Exercise: Joint Mobility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Resistance: red TB

Exercise #2

Exercise Name: Seated Row

Reason for Exercise: Strengthening

Location/Body Area: Thoracic Spine; Shoulder

Sets/Reps: 3x10

Resistance: red TB

Exercise #3

Exercise Name: Supine shoulder flexion WAND

Reason for Exercise: Flexibility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Manual Therapy (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance, MET to promote left shoulder flexion. Left median and radial pumps/glides in supine.

Total Minutes (All Manual Therapy): 10

Unrestricted left shoulder AROM in all planes. Absent significant left shoulder or elbow weakness.

Assessment: Unspecific left shoulder and elbow pain complaints triggered by daily activity involving playing with her computer and phone, housekeeping. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments including overhead activities, vacuuming, cooking.

Plan for Next Visit: Physical therapy intervention will emphasize therapeutic exercise, neuromuscular re-education, manual therapy, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 25****Total Treatment Minutes: 25**

Author: Jose Traverso, DPT 9/23/2019 15:04

Electronically signed by Traverso, Jose, DPT at 9/23/2019 3:06 PM



Brown, Jennifer Lyn

PAGE: 36 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/3/2019, D/C: 10/3/2019

10/03/2019 - FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 10/3/2019 12:33 PM

Author: Traverso, Jose, DPT

Service: —

Author Type: Physical Therapist

Filed: 10/3/2019 1:20 PM

Date of Service: 10/3/2019 12:33 PM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic

Treatment Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

Tel 570-887-4801

Fax 570-887-5830

Treatment Number: 4

Referring Physician: Michael F Gillan

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Time In: 1230

Time Out: 1300

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: Patient reports sickness for the last week, non contagious at this time. Reports improvement left shoulder condition from initial encounter, able to lie on her left side without significant pain. No worse after today's encounter.

Interventions:

Therapeutic Exercises (97110)

Patient Education/Home Exercise Program: yes

Number of Exercises?: 5

Total Minutes (all Therapeutic Exercise): 25



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 10/3/2019, D/C: 10/3/2019

10/03/2019 - FOLLOW UP in RPH Physical Therapy (continued)**Other Provider Notes (continued)****Exercise #1**

Exercise Name: Supine AA left shoulder flexion, progressed to manually resisted ER

Reason for Exercise: Joint Mobility

Location/Body Area: Shoulder; Left

Sets/Reps: 3x10 ea

Resistance: manual resistance

Exercise #2

Exercise Name: Seated Row

Reason for Exercise: Strengthening

Location/Body Area: Thoracic Spine; Shoulder

Sets/Reps: 3x10

Resistance: green TB

Exercise #3

Exercise Name: Supine shoulder flexion WAND

Reason for Exercise: Flexibility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Exercise #4

Exercise Name: Wall push ups

Reason for Exercise: Strengthening

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Exercise #5

Exercise Name: Wall slides

Reason for Exercise: Joint Mobility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 2x10

Unrestricted left shoulder AROM, minimal endrange flexion restriction. Absent significant left shoulder weakness in all planes.

Assessment: Patient demonstrates improved left shoulder mobility and muscular response to activity. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments including sustained housekeeping activities involving vacuuming and cleaning dishes.

Plan for Next Visit: Physical therapy intervention will emphasize therapeutic exercise, neuromuscular re-education, manual therapy, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 25

Total Treatment Minutes: 25



GUTHRIE

Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/3/2019, D/C: 10/3/2019

EXHIBIT NO. B14F

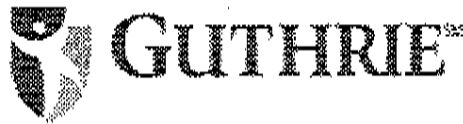
PAGE: 38 OF 76

10/03/2019 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Author: Jose Traverso, DPT 10/3/2019 13:17

Electronically signed by Traverso, Jose, DPT at 10/3/2019 1:20 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 10/10/2019, D/C: 10/10/2019
EXHIBIT NO. B14F
PAGE: 39 OF 76

10/10/2019 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 10/10/2019 3:30 PM

Author: Traverso, Jose, DPT Service: — Author Type: Physical Therapist
Filed: 10/10/2019 4:00 PM Date of Service: 10/10/2019 3:30 PM Status: Signed
Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic
Treatment Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 5

Referring Physician: Michael F. Gillan

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Time In: 1530

Time Out: 1600

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

Subjective Comments: Improved left shoulder mobility, tolerance to reaching. RA flare up, changing medication.
Better after today's encounter.

Interventions:

Therapeutic Exercises (97110)
Patient Education/Home Exercise Program: yes
Number of Exercises?: 7
Total Minutes (all Therapeutic Exercise): 25

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Brown, Jennifer Lyn

PAGE: 40 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/10/2019, D/C: 10/10/2019

10/10/2019 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)**Exercise #1**

Exercise Name: Supine AA left shoulder flexion, progressed to manually resisted ER

Reason for Exercise: Joint Mobility

Location/Body Area: Shoulder; Left

Sets/Reps: 3x8 ea

Resistance: manual resistance

Exercise #2

Exercise Name: Seated Row

Reason for Exercise: Strengthening

Location/Body Area: Thoracic Spine; Shoulder

Sets/Reps: 3x10

Resistance: green TB

Exercise #3

Exercise Name: Supine shoulder flexion WAND

Reason for Exercise: Flexibility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Exercise #4

Exercise Name: Wall push ups

Reason for Exercise: Strengthening

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 3x10

Exercise #5

Exercise Name: Wall slides

Reason for Exercise: Joint Mobility

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 2x10

Exercise #6

Exercise Name: Scapular unilateral retraction

Reason for Exercise: Strengthening

Location/Body Area: Left; Shoulder

Sets/Reps: 2x10

Resistance: green TB

Exercise #7

Exercise Name: Bilateral shoulder ER

Reason for Exercise: Strengthening

Location/Body Area: Bilateral; Shoulder

Sets/Reps: 2x10

Resistance: green TB

Assessment: Patient demonstrates improved left shoulder AROM, tolerance to overhead activities. Skilled

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Brown, Jennifer Lyn

PAGE: 41 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/10/2019, D/C: 10/10/2019

10/10/2019 FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Physical Therapy services are required to address ongoing functional and objective limitations/impairments including sustained overhead activities.

Plan for Next Visit: Physical therapy intervention will emphasize therapeutic exercise, neuromuscular re-education, manual therapy, modalities to control pain as deemed appropriate.
Anticipate D/C next encounter.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 25****Total Treatment Minutes: 25**

Author: Jose Traverso, DPT 10/10/2019 15:55

Electronically signed by Traverso, Jose, DPT at 10/10/2019 4:00 PM



Brown, Jennifer Lyn

PAGE: 42 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 10/16/2019, D/C: 10/16/2019

10/16/2019 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 10/16/2019 12:07 PM

Author: Traverso, Jose, DPT

Service: —

Author Type: Physical Therapist

Filed: 10/16/2019 12:31 PM

Date of Service: 10/16/2019 12:07 PM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic
Discharge Note
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Treatment Number: 6

Discharge note from 9/17/19 to 10/16/19

Referring Physician: Michael F Gillan

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Impingement syndrome of left shoulder	726.2	M75.42
2. Left elbow pain	719.42	M25.522

Time In: 1210

Time Out: 1230

Total Session Minutes: 20

Pain at Start of Care: 1/10

Pain at End of Care: 1/10

Subjective Comments: General improvement from initial encounter. Improved tolerance to carrying groceries, overhead activities. Able to walk her dogs, minimal shoulder pain at night.

Interventions:

Manual Therapy (97140)

Joint Mobilization Details: Left glenohumeral mobilization grade 3-4 cranio-caudal and AP, rhythmic and sustained, tolerated well. Left shoulder posterior capsular stretch. Resisted left shoulder ER, manual resistance. MET to promote left shoulder flexion. Left median and radial pumps/glides ni supine.

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 10/16/2019, D/C: 10/16/2019

PAGE: 43 OF 76

10/16/2019 FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Total Minutes (All Manual Therapy): 20

Objective:

No significant deformity to superficial exam. No increased temperature, no swelling, redness or echymosis observed. Significant cervico-thoracic postural dysfunction: forward cervical spine, hyphotic, prominent CTJ. Dermatome exam C1-T1 to superficial pin/prick does not reveal sensory dysfunction. Deep Tendon Reflexes (bicipital, tricipital, brachioradialis) equal and symmetric, graded +2. Left shoulder ROM does not reveal significant restrictions or crepitus in all planes. Left shoulder Muscle Testing does not reveal significant weakness. No significant restriction observed during the exam of gleno-humeral, acromio-clavicular, sterno-clavicular or scapulo-thoracic joints.

Goals: All goals achieved

Pain: Patient will report decrease in left shoulder pain to 2/10 or less when performing overhead activities, vacuuming, left sidelying.

Posture: Patient will demonstrate good awareness of proper sitting posture without cuing from therapist. Able to lift her dog (<20 lbs) without significant left shoulder pain

Assessment: Essentially normal left shoulder exam. Improved left shoulder AROM and tolerance to overhead activity. Improved general mobility, pain response to ADLs.

D/C at this time. Continue HEP pm.

Total UNTIMED Code Treatment Minutes:

Total TIMED Code Treatment Minutes: 20

Total Treatment Minutes: 20

Author: Jose Traverso, DPT 10/16/2019 12:29

Electronically signed by Traverso, Jose, DPT at 10/16/2019 12:31 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 12/23/2019, D/C: 12/23/2019

EXHIBIT NO. B14F

PAGE: 44 OF 76

12/23/2019 - US GENERAL in Robert Packer US

Imaging

Imaging

US LOWER EXTREMITY NON VASCULAR LIMITED LEFT [163840194] (Final result)

US LOWER EXTREMITY NON VASCULAR LIMITED LEFT [163840194]
(Abnormal)

Resulted: 12/23/19 1606, Result status: Final result

Ordering provider: Gillan, Michael F, DO 12/23/19 1405

Order status: Completed

Resulted by: Collins, Andrew J, MD

Filed by: Interface, Rad Results 12/23/19 1608

Performed: 12/23/19 1415 - 12/23/19 1504

Accession number: 6009714

Narrative:

Procedure(s): US LOWER EXTREMITY NON VASCULAR LIMITED LEFT

Date of service: 12/23/2019 2:15 PM

Provided clinical information: 43 years, Female, "swelling behind left knee, suspect baker's cyst"

Procedure and materials: Grayscale and color Doppler imaging of the left knee popliteal region was performed.

Comparison studies: Right knee radiographs with images of the left 7/6/2018. Left knee radiographs 3/22/2018.

Observations:

Negative for evidence of popliteal cyst/Baker's cyst.

The distal biceps femoris tendon appears somewhat hypoechoic which could relate to tendinosis. Patient's region of pain is at the region of the distal biceps tendon. Negative for discrete tendon tear.

There is a small to moderate size knee joint effusion with fluid in the suprapatellar pouch and lateral saddle bag with moderate synovial thickening without prominent increased vascularity.

Impression:

Ultrasound of the left knee with attention to the popliteal region:

1. Negative for evidence of popliteal cyst.
2. Small to moderate size knee joint effusion with moderate synovial thickening.
3. Appearance that could represent mild tendinosis of the distal biceps tendon with patient noting some pain when the transducer was placed over the region.

Urgency: IMPORTANT. This report contains IMPORTANT results which require clinical attention.

Recommendation: No specific imaging recommendation.

Signed by Andrew Collins on 12/23/2019 4:06 PM

Acknowledged by: Gillan, Michael F, DO on 12/24/19 1548

Indications

Pain and swelling of knee, left [M25.562, M25.462 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 12/26/2019 9:46 AM



GUTHRIE

Brown, Jennifer Lyn

PAGE: 45 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/22/2020, D/C: 1/22/2020

01/22/2020 - XR GENERAL in Robert Packer XR

Imaging

Imaging

XR KNEE 4 OR MORE VIEWS LEFT (STANDARD) [168104680] (Final result)

XR KNEE 4 OR MORE VIEWS LEFT (STANDARD) [168104680]

Resulted: 01/28/20 1537, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/22/20 0851

Order status: Completed

Resulted by:

Filed by: Interface, Rad Results 01/28/20 1540

Ronsivalle, Joseph, DO, FSIR

Lynch, Michael T, RPA

Performed: 01/22/20 0855 - 01/22/20 0908

Accession number: 6040854

Narrative:

Procedure(s): XR KNEE 4 OR MORE VIEWS LEFT (STANDARD)

Date of service: 1/22/2020 8:55 AM

Provided clinical information: 43 years, Female, "pain, discomfort, swelling"

Procedure and materials: Upright views of bilateral knees were obtained in AP and AP flexion positions as well as bilateral patellar views and a lateral view of the left knee.

Comparison studies: The x-rays performed July 6, 2018

Observations:

Normal bony mineralization. No fracture or dislocation is identified. No lytic or blastic lesion is seen.

No joint effusion. Joint space heights are relatively well-maintained. Femorotibial joint space height is relatively well maintained. There is mild joint space narrowing of the patellofemoral joint space with small posterior patellar osteophytes. Alignment is anatomic.

Soft tissue structures are normal.

Impression:

Minimal degenerative arthritis of the left patellofemoral joint as described.

Report transcribed by Michael Lynch, RPA/RA.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Joseph Ronsivalle has reviewed the images and preliminary report.

Signed by Joseph Ronsivalle on 1/28/2020 3:37 PM

Acknowledged by: Gillan, Michael F, DO on 01/29/20 0834

Indications

Acute pain of left knee [M25.562 (ICD-10-CM)]

All Reviewers List

Gillan, Michael F, DO on 1/29/2020 8:34 AM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 1/29/2020, D/C: 1/29/2020

EXHIBIT NO. B14F

PAGE: 46 OF 76

01/29/2020 Admission (Discharged) in RPH RECOVERY

Labs

Lab

Tissue exam [169308264] (Final result)

Specimen Information

ID	Type	Source	Collected By
1	Tissue	Other	Georgetson, Michael J, MD FACG 01/29/20 0933
2	Tissue	colon biopsy	Georgetson, Michael J, MD FACG 01/29/20 0934

Tissue exam [169308264]

Resulted: 01/30/20 1213, Result status: Final result

Ordering provider: Georgetson, Michael J, MD FACG
01/29/20 0933
Filed by: Sarker, Ashit B, MD, PhD 01/30/20 1213

Order status: Completed

Collected by:
Georgetson, Michael J, MD FACG 01/29/20 0933
Georgetson, Michael J, MD FACG 01/29/20 0934

Resulting lab: GUTHRIE MEDICAL GROUP LABORATORY
Acknowledged by
Georgetson, Michael J, MD FACG on 01/30/20 1342
Gillan, Michael F, DO on 01/30/20 1503
Shaw, Beth, RN on 01/30/20 1529

Components

Component	Value	Reference Range	Flag	Lab
Case Report	-	-	-	GMG
Result:				
Surgical Pathology	Case: SP20-01877			
Authorizing Provider: Georgetson, Michael J, MD FACG	Collected:	01/29/2020 09:33 AM		
Ordering Location: RPH RECOVERY	Received:	01/29/2020 10:53 AM		
Pathologist: Sarker, Ashit B, MD, PhD				
Specimens: 1) - OTHER (WRITE ON SPECIMEN), biopsy terminal illum erosions H/O Crohns				
2) - colon biopsy, biopsy entire colon normal appearance H/O Crohn's				
Pre-Op Diagnosis	-	-	-	GMG
Result:				
K50.10 - Crohn's disease of colon without complication (HCC) [ICD-10-CM]				
R10.31 - RLQ abdominal pain [ICD-10-CM]				
K21.9 - Gastroesophageal reflux disease, esophagitis presence not specified [ICD-10-CM]				
Post-Op Diagnosis	-	-	-	GMG
Result:				
K50.10 - Crohn's disease of colon without complication (HCC) [ICD-10-CM]				
R10.31 - RLQ abdominal pain [ICD-10-CM]				
K21.9 - Gastroesophageal reflux disease, esophagitis presence not specified [ICD-10-CM]				
FINAL DIAGNOSIS	-	-	-	GMG
Result: 1. Terminal ileum erosions, biopsy:				
-Mildly active chronic ileitis.				
-No evidence of dysplasia.				
2. Random entire colon biopsy:				
-Fragments of colonic mucosa, no pathologic abnormality detected.				
Electronically signed by Sarker, Ashit B, MD, PhD on 1/30/2020 at 12:13 PM				
Microscopic Description	-	-	-	GMG
Result: Microscopic examination is performed.				
Gross Description	-	-	-	GMG
Result: 1. The specimen is received in formalin labeled, with the patient's name, MRN, and biopsy terminal illum erosions H/O Crohns and consists of multiple tan irregular soft tissue fragments with aggregate dimensions of 0.8 x 0.6 x 0.3 cm. The specimen is submitted in toto in cassette 1A..				

1078



Brown, Jennifer Lyn

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/29/2020, D/C: 1/29/2020

EXHIBIT NO. B14F

PAGE: 47 OF 76

01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Labs (continued)

2. The specimen is received in formalin labeled, with the patient's name, MRN, and biopsy entire colon normal appearance H/O Crohn's and consists of multiple tan irregular soft tissue fragments that aggregate dimensions of 1.0 x 0.7 x 0.2 cm. The specimen is submitted in toto in cassette 2A.
NJL

Gross description is reviewed before signout by Ashit B Sarker, MD, PhD

Disclaimer

GMG

Result Gross description is performed at the Guthrie Medical Group Laboratory, 1 Guthrie Square, Sayre, PA 18840.

All technical components are performed at the Guthrie Medical Group Laboratory, 1 Guthrie Square, Sayre, PA 18840.

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
6 -	GMG	GUTHRIE MEDICAL GROUP LABORATORY	Hojjati, Hani, MD	1 GUTHRIE SQUARE SAYRE PA 18840	07/31/18 1407 - Present

Indications

Crohn's disease of colon without complication (HCC) [K50.10 (ICD-10-CM)]
RLQ abdominal pain [R10.31 (ICD-10-CM)]
Gastroesophageal reflux disease, esophagitis presence not specified [K21.9 (ICD-10-CM)]

All Reviewers List

Shaw, Beth, RN on 1/30/2020 3:29 PM
Georgetson, Michael J, MD FACG on 1/30/2020 3:12 PM
Gillan, Michael F, DO on 1/30/2020 3:03 PM

Procedures

Procedures

COLONOSCOPY REPORT [169308266] (Final result)

Specimen Information

ID	Type	Source	Collected By
663291	—	—	01/29/20 0849

COLONOSCOPY REPORT [169308266]

Resulted: 01/29/20 0941, Result status: Final result

Ordering provider: Gillan, Michael F, DO 01/29/20 0849

Order status: Completed

Resulted by: Georgetson, Michael J, MD FACG

Filed by: Interface, Multispecialty Results 01/29/20 0941

Collected by: 01/29/20 0849

Resulting lab: PROVATION

Acknowledged by: Gillan, Michael F, DO on 01/29/20 0947

Components

Component	Value	Reference Range	Flag	Lab
GI Procedure	—	—	—	PROV

1079



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 1/29/2020, D/C: 1/29/2020
EXHIBIT NO. B14F
PAGE: 48 OF 76

01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Procedures (continued)

Result:
Robert Packer Hospital

Patient Name: Jennifer Lyn Brown Procedure Date: 1/29/2020 8:49 AM
MRN: 340616 Account Number: 80220922
Date of Birth: 10/26/1976 Admit Type: Outpatient
Age: 43 Room: OR
Gender: Female Note Status: Finalized
Attending MD: MICHAEL J GEORGETSON, MD FACG Instrument Name: 9794 CF HQ 190L

Procedure: Colonoscopy
Indications: Abdominal pain in the right lower quadrant, Abdominal pain
in the right upper quadrant, Crohn's disease of the small
bowel
Providers: MICHAEL J. GEORGETSON, MD FACG, Abigail Perry, RN (Nurse)
Referring MD: MICHAEL F. GILLAN, DO (Referring MD)
Medicines: Monitored Anesthesia Care
Complications: No immediate complications.

Procedure: The patient's current medications and allergies were
reviewed and recorded in the nurses notes. The patient was
made aware of the risk of the procedure which can include:
bleeding, infection, perforation, an adverse reaction to
sedation, and a risk of missed lesions, among others. The
patient appeared to understand. An opportunity for
questions was provided, and an informed consent form was
signed. The scope was passed under direct vision.
Throughout the procedure, the patient's blood pressure,
pulse EKG, and oxygen saturations were monitored
continuously. The Colonoscope was introduced through the
anus and advanced to the terminal ileum, with
identification of the appendiceal orifice and IC valve.
The colonoscopy was performed without difficulty. The
patient tolerated the procedure well. The quality of the
bowel preparation was good.

Findings:
The terminal ileum contained a few localized non-bleeding erosions.
Biopsies were taken with a cold forceps for histology.
The rectum, sigmoid colon, descending colon, transverse colon, ascending
colon and cecum appeared normal. Biopsies were taken with a cold forceps
for histology.
External and internal hemorrhoids were found during retroflexion, during
perianal exam, during digital exam and during endoscopy. The hemorrhoids
were Grade I (internal hemorrhoids that do not prolapse).

Impression: - A few erosions in the terminal ileum. Biopsied.
- The rectum, sigmoid colon, descending colon, transverse
colon, ascending colon and cecum are normal. Biopsied.
- External and internal hemorrhoids.

Recommendation: - Discharge patient to home.
- High fiber diet indefinitely.
- Continue present medications.
- Await pathology results.
- Repeat colonoscopy (date not yet determined) for
surveillance based on pathology results.
- Follow-up sooner per change in status, symptom changes
or development, change in risk factors, etc.
- Polyps can be missed.
- Return to referring physician as previously scheduled.
- Patient has a contact number available for emergencies.
The signs and symptoms of potential delayed complications



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 1/29/2020, D/C: 1/29/2020

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01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Procedures (continued)

were discussed with the patient. Return to normal activities tomorrow. Written discharge instructions were provided to the patient
- If you have a medical emergency, call 911 immediately.
- Anusol HC 1, Tucks with Hydrocortisone, or Preparation H with Hydrocortisone cream (available OTC) bid-qid prn.

Procedure Code(s): — Professional —
45380, Colonoscopy, flexible; with biopsy, single or multiple

Diagnosis Code(s): — Professional —
K63.3, Ulcer of intestine
K64.0, First degree hemorrhoids
R10.31, Right lower quadrant pain
R10.11, Right upper quadrant pain
K50.00, Crohn's disease of small intestine without complications

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The codes documented in this report are preliminary and upon coder review may be revised to meet current compliance requirements.

MICHAEL J GEORGETSON, MD FACG
1/29/2020 9:40:56 AM
This report has been signed electronically.
Number of Addenda: 0

Note Initiated On: 1/29/2020 8:49 AM
CC Letter to: MICHAEL F. GILLAN, DO (CC)

View Image (below)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
53 - PROV	PROVATION	Unknown	Unknown	01/23/13 0830 - Present

All Reviewers List

Gillan, Michael F, DO on 1/29/2020 9:47 AM

UPPER GI ENDOSCOPY REPORT [169308262] (Edited Result - FINAL)

Specimen Information

ID	Type	Source	Collected By
668769	—	—	01/29/20 0850

Resulted: 01/30/20 1312, Result status: Edited

UPPER GI ENDOSCOPY REPORT [169308262]

Result - FINAL

Ordering provider: Gillan, Michael F, DO 01/29/20 0850
Resulted by: Georgetown, Michael J, MD FACG
Collected by: 01/29/20 0850
Acknowledged by: Gillan, Michael F, DO on 01/30/20 1503

Order status: Completed
Filed by: Interface, Multispecialty Results 01/30/20 1312
Resulting lab: PROVATION

Components

Component	Value	Reference Range	Flag	Lab
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EXHIBIT NO. B14F
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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 1/29/2020, D/C: 1/29/2020

01/29/2020 Admission (Discharged) in RPH RECOVERY (continued)

Procedures (continued)

Upper GI endoscopy

PROV

Result:

Robert Packer Hospital

Patient Name: Jennifer Lyn Brown Procedure Date: 1/29/2020 8:50 AM
MRN: 340616 Account Number: 80220922
Date of Birth: 10/26/1976 Admit Type: Outpatient
Age: 43 Room: OR
Gender: Female Note Status: Supervisor Override
Attending MD: MICHAEL J GEORGETSON, MD FACG Instrument Name: 9022-GIF-HQ190

Procedure: Upper GI endoscopy

Indications: Abdominal pain in the right upper quadrant, Abdominal pain
in the right lower quadrant, Crohn's disease

Providers: MICHAEL J. GEORGETSON, MD FACG, Abigail Perry, RN (Nurse)

Referring MD: MICHAEL F. GILLAN, DO (Referring MD)

Medicines: Monitored Anesthesia Care

Complications: No immediate complications.

Procedure: The patient's current medications and allergies were reviewed and recorded in the nurses notes. The patient was made aware of the risk of the procedure which can include: bleeding, infection, perforation, an adverse reaction to sedation, and a risk of missed lesions, among others. The patient appeared to understand. An opportunity for questions was provided, and an informed consent form was signed. The scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse EKG, and oxygen saturations were monitored continuously. The Endoscope was introduced through the mouth, and advanced to the third part of duodenum. The Z-line was located at
The upper GI endoscopy was accomplished without difficulty. The patient tolerated the procedure well.

Findings:

The esophagus was normal.
A 2 cm hiatal hernia was present.
The exam of the stomach was otherwise normal.
The examined duodenum was normal.

Impression: - Normal esophagus.

- 2 cm hiatal hernia.
- Normal examined duodenum.
- No specimens collected.

Recommendation: -- Discharge patient to home (ambulatory).

- Follow an antireflux regimen indefinitely.
 - Continue present medications.
 - Return to referring physician as previously scheduled.
 - Patient has a contact number available for emergencies.
- The signs and symptoms of potential delayed complications were discussed with the patient. Return to normal activities tomorrow. Written discharge instructions were provided to the patient
- If you have a medical emergency, call 911 immediately.

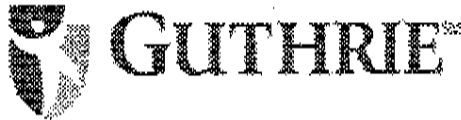
Procedure Code(s): -- Professional --

43235, Esophagogastroduodenoscopy, flexible, transoral;
diagnostic, including collection of specimen(s) by
brushing or washing, when performed (separate procedure)

Diagnosis Code(s): -- Professional --

K44.9, Diaphragmatic hernia without obstruction or gangrene

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Brown, Jennifer Lyn

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Adm: 1/29/2020, D/C: 1/29/2020

01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Procedures (continued)

R10.11, Right upper quadrant pain

R10.31, Right lower quadrant pain

K50.90, Crohn's disease, unspecified, without complications

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The codes documented in this report are preliminary and upon coder review may be revised to meet current compliance requirements.

MICHAEL J GEORGETSON, MD FACG

1/29/2020 9:12:54 AM

This report has been signed electronically.

Number of Addenda: 0

Note Initiated On: 1/29/2020 8:50 AM

CC Letter to: MICHAEL F. GILLAN, DO (CC)

[View Image \(below\)](#)**Testing Performed By**

Lab - Abbreviation	Name	Director	Address	Valid Date Range
53 - PROV	PROVATION	Unknown	Unknown	01/23/13 0830 - Present

All Reviewers List

Gillan, Michael F, DO on 1/30/2020 3:03 PM



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 1/29/2020, D/C: 1/29/2020
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01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Documents

Lab Result Document - Document on 1/30/2020 12:13 PM by Sarker, Ashit B, MD, PhD

Document (below)

Guthrie Medical
Group Laboratory

1 Guthrie Square, Sayre, PA 18840
Phone: 570-887-4160
Fax: 570-887-4193
Medical Director: Hani Rejjati, MD

Brown, Jennifer Lyn 340616
F, 43 yrs, 10/26/1976
14 MAIN ST LOT 429, WELLSBURG NY 14894
H: 607-215-0884 M: 607-483-1888

Authorizing Provider

Georgetown, Michael J, MD FAGG O: 570-887-2852
1 GUTHRIE SQUARE, SAYRE PA 18840

Surgical Pathology (Final result) SP20-01877

Authorizing Provider:	Georgetown, Michael J, MD FAGG	Ordering Provider:	Georgetown, Michael J, MD FAGG
Ordering Location:	RPH RECOVERY	Collected:	01/29/2020 0933
Pathologist:	Sarker, Ashit B, MD, PhD	Received:	01/29/2020 1053

Specimens

- 1 OTHER (WRITE ON SPECIMEN), biopsy terminal ileum erosions H/O Crohn's
- 2 colon biopsy, biopsy entire colon normal appearance H/O Crohn's

Pre-Op Diagnosis

K50.10 - Crohn's disease of colon without complication (HCC) [ICD-10-CM]
R10.31 - RLQ abdominal pain [ICD-10-CM]
K21.9 - Gastroesophageal reflux disease, esophagitis presence not specified [ICD-10-CM]

Post-Op Diagnosis

K50.10 - Crohn's disease of colon without complication (HCC) [ICD-10-CM]
R10.31 - RLQ abdominal pain [ICD-10-CM]
K21.9 - Gastroesophageal reflux disease, esophagitis presence not

Patient: Brown, Jennifer
Lyn
MRN: 340616

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Printed: 1/30/2020 12:13



Brown, Jennifer Lyn

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Adm: 1/29/2020, D/C: 1/29/2020

01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Documents (continued)

Guthrie Medical
Group Laboratory

1 Guthrie Square, Sayre, PA 18840

Phone: 570-867-4180

Fax: 570-867-4193

Medical Director: Henri Holjati, MD

specified [ICD-10-CM]

FINAL DIAGNOSIS

1. Terminal ileum erosions, biopsy:

-Mildly active chronic ileitis.

-No evidence of dysplasia.

2. Random entire colon biopsy:

-Fragments of colonic mucosa, no pathologic abnormality detected.

Electronically signed by Sarker, Ashit B, MD, PhD on 1/30/2020 at 1213

Microscopic Description

Microscopic examination is performed.

Gross Description

1. The specimen is received in formalin labeled, with the patient's name, MRN, and biopsy terminal ileum erosions H/O Crohn's and consists of multiple tan irregular soft tissue fragments with aggregate dimensions of 0.8 x 0.6 x 0.3 cm. The specimen is submitted in toto in cassette 1A.

2. The specimen is received in formalin labeled, with the patient's name, MRN, and biopsy entire colon normal appearance H/O Crohn's and consists of multiple tan irregular soft tissue fragments that aggregate dimensions of 1.0 x 0.7 x 0.2 cm. The specimen is submitted in toto in cassette 2A.
NJL.

Gross description is reviewed before signout by Ashit B Sarker, MD, PhD

Disclaimer

Gross description is performed at the Guthrie Medical Group Laboratory, 1 Guthrie Square, Sayre, PA 18840.

Patient: Brown, Jennifer
Lyn
MRN: 340616

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Printed: 1/30/2020 12:13



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 1/29/2020, D/C: 1/29/2020

01/29/2020 - Admission (Discharged) in RPH RECOVERY (continued)

Documents (continued)

Guthrie Medical
Group Laboratory

1 Guthrie Square, Sayre, PA 18840

Phone: 570-887-4160

Fax: 570-887-4193

Medical Director: Hani Hojjati, MD

All technical components are performed at the Guthrie Medical Group Laboratory, 1
Guthrie Square, Sayre, PA 18840.

Resulting Labs

GMC	GUTHRIE MEDICAL GROUP LABORATORY, 1 GUTHRIE SQUARE, SAYRE PA 18840 Director: Hojjati, Hani, MD	570-887-4719
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Patient: Brown, Jennifer
Lyn
MRN: 340616

Page: 3 of 3

Printed: 1/30/2020 12:13



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/4/2020, D/C: 3/4/2020

03/04/2020 - EVALUATION in RPH Physical Therapy

Clinic Notes

Therapy Plan of Care

Traverso, Jose, DPT at 3/4/2020 12:02 PM

Author: Traverso, Jose, DPT

Service: FAMILY PRACTICE

Author Type: Physical Therapist

Filed: 3/4/2020 12:04 PM

Date of Service: 3/4/2020 12:02 PM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

Cosigner: Gillan, Michael F, DO at

3/4/2020 12:26 PM

The Guthrie Clinic
Initial Evaluation Plan of Care
Outpatient Physical Therapy Services
 ROBERT PACKER HOSPITAL
 RPH PHYSICAL THERAPY
 1 GUTHRIE SQUARE
 SAYRE PA 18840-1625
 Tel 570-887-4801
 Fax 570-887-5830

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 3/4/2020

Referring Physician: Michael F Gillan

Plan of Care Start Date: 03/04/20

Plan of Care Expiration Date: 06/04/20

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Acute pain of left knee	719.46	M25.562

Prior Functional Status:

Current Functional Status:

Rehabilitative Prognosis: Poor

Goals: Regular Home Exercise Program performance to promote active life style.

Planned Intervention(s): PT Eval Moderate Complexity (97162); Neuro Re-Education (97112); Therapeutic Exercise (Timed) (97110); Ultrasound (Timed) (97035); Manual Therapy (Timed) (97140); E-Stim (Commercial) (97014)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/4/2020, D/C: 3/4/2020

03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Clinic Notes (continued)

Frequency of Treatment: 1 time for HEP review

Duration of Treatment: 1 month

The Physical Therapy Plan of Care has been discussed with the patient. Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under my care.

Gillan, Michael F, DO
1 GUTHRIE SQUARE
SAYRE, PA 18840 (To be Electronically signed)

Author: Jose Traverso, DPT 3/4/2020 12:02

Electronically signed by Traverso, Jose, DPT at 3/4/2020 12:04 PM

Electronically signed by Gillan, Michael F, DO at 3/4/2020 12:28 PM

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 3/4/2020 11:12 AM

Author: Traverso, Jose, DPT

Service: —

Author Type: Physical Therapist

Filed: 3/4/2020 12:04 PM

Date of Service: 3/4/2020 11:12 AM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic
Initial Evaluation
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 3/4/2020

Patient Name: Jennifer Lyn Brown

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Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 3/4/2020, D/C: 3/4/2020
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03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Patient MRN: 340616
Order Date: 1/21/2020
Order ID: 168104678
Order Description: Refer To Physical Therapy / Rehab

Plan of Care Expiration Date: 06/04/20

Referring Physician: Michael F Gillan

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Acute pain of left knee	719.46	M25.562

Time In: 1100
Time Out: 1200

Patient Precautions: RA, obesity, depression, fibromyalgia

Subjective: She is a 43-y.o.-year-old female who presents for outpatient physical therapy with a chief complaint of left knee pain since January 2020 without traumatic event.

Height: 5'11"
Weight: 280 lbs

What is your profession? Does not work currently. Not working since May 2019
Weight lifting requirements? No
Are you working currently? No

HPI: Patient intermittent reports distal biceps femoris area, triggered by descending stairs. Occasional left knee "give out" episodes. Denies left LE pain or paresthesias. Reports left buttock pain since January without traumatic event. Occasional left knee pain in bed when flexion activities.

History of previous injuries pertinent to your pain: denies any
History of previous related surgeries: denies any
When did your pain start? January 2020
Where is your pain located? Left distal biceps femoris
Is your pain constant or intermittent? Intermittent
Distal paresthesias? No
Can you elicit distal symptoms with proximal movement? No
Alleviating factors? Sitting on heating pad
Aggravating factors? Ambulation > 1 block

Red Flags?

Patient denies diplopia, dysphagia, dysarthria, dizziness or drop attacks. Denies significant photophobia or

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/4/2020, D/C: 3/4/2020

03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

sonophobia. Denies tinnitus. Denies upper lip or facial paresthesias, facial paralysis or difficulty to express emotions with facial expression. Denies feelings of spinal instability, new bowel or bladder incontinence. Denies saddle anesthesia, widespread limbs weakness or inability to evacuate bladder. Denies localized acute findings: throbbing, increased local temperature or effusion. Denies constitutional signs, fevers, chills or unexplained weight changes. Denies gnawing, lacerating pain in repose that disturbs sleep cycle.

Is your pain improving from initial onset? Yes No

Because of your pain, how long can you walk until you need to sit down? 1 block

Because of your pain, how long can you sit until you need to stand? 1 hour

Are you taking any medication related to your pain? Tylenol and Flexeril with good results

Are you being physically abused? No

Objective:

No significant deformity to superficial exam. No increased temperature, no swelling, redness or echymosis observed. No effusion observed. Patient ambulates approximately 50 feet without significant restrictions. Dermatomal exam L1-S1 to superficial pin/prick does not reveal sensory dysfunction. Deep Tendon Reflexes (Patellar, Achilles) equal and symmetric, graded +2. Bilateral knees and hips AROM exam does not reveal significant restrictions in all planes. No significant restriction to the exam of bilateral patello-femoral ant tibio-fibular joints. Manual Muscle Testing does not reveal significant weakness myotomes L1 to S1. Negative Thessaly, McMurray, Lachmann, anterior and posterior drawers, valgus and varus tests. No significant tenderness to femoro-tibial joint line palpation.

Past Medical History:

Diagnosis	Date
• Anal fissure	1/2013
• Anxiety	
• Attention deficit	
• Back ache	3/18/2014
• Calcaneal spur	6/30/2008
• Cherry angioma	8/9/2016
• Cholecystitis	
• CHRONIC SINUSITIS NOS	5/23/2005
CT 2005	
• Crohn disease (HCC)	
• Depression	1/20/2014
• Endocrine problem	
• Epicondylitis elbow, medial	10/7/2008
• Fatty liver	
• Fibromyalgia	8/20/2014
• Fractures	
• Gastroparesis	
irritable bowel syndrome	
• GERD (gastroesophageal reflux disease)	10/7/2008
• HTN (hypertension), benign	10/7/2008
• Hypertension	
• Morbidly obese (HCC)	



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 3/4/2020, D/C: 3/4/2020
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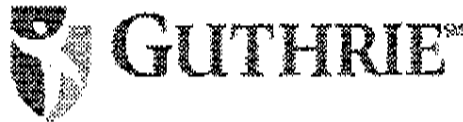
03/04/2020 EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

- Multinodular goiter
- Nontoxic multinodular goiter 1/18/2011
- Obesity
- Persistent mental disorders due to conditions classified elsewhere
- Physiological ovarian cysts 10/7/2008
- PLANTAR FIBROMATOSIS 9/9/2004
- Premenopausal patient
- Rheumatoid arthritis(714.0) 12/12/2008
- Sees Dr. Freeman in Elmira.
- Severe obstructive sleep apnea 6/10/2013
- Sleep apnea
- Thyroid nodule 6/3/2010
- Wrist fracture

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY	N/A	6/24/2016
<i>Procedure: COLONOSCOPY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY	N/A	6/2/2017
<i>Procedure: COLONOSCOPY ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• COLONOSCOPY	N/A	6/11/2018
<i>Procedure: COLONOSCOPY; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</i>		
• COLONOSCOPY	N/A	1/29/2020
<i>Procedure: COLONOSCOPY with biopsy; Surgeon: Georgetson, Michael J, MD FACG; Location: RPH MAIN OR</i>		
• COLONOSCOPY DIAGNOSTIC		
• EGD		2002
• EGD	N/A	8/13/2014
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Alley, Joshua, MD; Location: RPH MAIN OR; Laterality: N/A;</i>		
• EGD	N/A	6/24/2016
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD	N/A	6/2/2017
<i>Procedure: ENDOSCOPY UPPER GI w/BIOPSY; Surgeon: Sinh, Preetika, MD; Location: RPH MAIN OR</i>		
• EGD	N/A	6/11/2018
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: McDonald, Thomas J, MD; Location: RPH GI OR</i>		
• EGD	N/A	1/29/2020
<i>Procedure: ENDOSCOPY UPPER GI; Surgeon: Georgetson, Michael J, MD FACG; Location: RPH MAIN OR</i>		
• EGD (GUTHRIE / NON GUTHRIE)		
• LAPAROSCOPIC CHOLECYSTECTOMY		2013
<i>with liver biopsy</i>		



Brown, Jennifer Lyn
MRN: 340616, DOB: 10/26/1976, Sex: F
Adm: 3/4/2020, D/C: 3/4/2020

EXHIBIT NO. B14F

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03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

- PR CLOSED RX TARSAL FX, EACH
- PR LAP, GAST RESTRICT PROC, LONGITUDINAL GASTRECTOMY
for obesity - Dr. Alley - RPH 12/10/2014
- PR REMOVAL GALLBLADDER
- PR SHLDR ARTHROSCOP, PART ACROMIOPLAS Left 5/24/2019
Procedure: LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION,
DISTAL CLAVICLE EXCISION; Surgeon: Choi, Joseph, MD; Location: RPH MAIN OR
- TONSILLECTOMY 11/26/07

Current Outpatient Medications:

- ALPRAZolam (XANAX) 0.25 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED (increased anxiety). Max Daily Amount: 0.75 mg., Disp: 15 Tab, Rfl: 0
- amitriptyline (ELAVIL, ENDEP) 25 MG Oral Tab, Take 1 Tab by mouth EVERY BEDTIME., Disp: 90 Tab, Rfl: 0
- Blood Glucose Monitor Software Does not apply Device, 1 Device by Does not apply route AS DIRECTED. Brand: Insurance preferred, Disp: 1 Device, Rfl: 0
- buPROPion (WELLBUTRIN XL) 300 MG Oral TABLET SR 24 HR, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 1
- calcium carbonate (CALTRATE) 600 MG Oral Tab, Take 1 Tab by mouth TWICE DAILY., Disp: 60 Tab, Rfl: 5
- Cholecalciferol (VITAMIN D3) 25 MCG (1000 UT) Oral Cap, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 3
- cyclobenzaprine (FLEXERIL) 10 MG Oral Tab, Take 1 Tab by mouth THREE TIMES DAILY AS NEEDED for muscle spasm., Disp: 42 Tab, Rfl: 0
- EPINEPHrine 0.3 MG/0.3ML Injection Solution Auto-injector, 0.3 mg by Injection route AS NEEDED (bee sting)., Disp: 1 Each, Rfl: 3
- fluconazole (DIFLUCAN) 200 MG Oral Tab, Take 1 Tab by mouth AS DIRECTED. May take 1 tab on day 3 or 4 and again on day 10, Disp: 2 Tab, Rfl: 0
- fluticasone (FLONASE) 50 MCG/ACT Nasal Suspension, Spray 2 Sprays in nose DAILY., Disp: 1 Bottle, Rfl: 0
- foliC acid 1 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 90 Tab, Rfl: 3
- Glucose Blood (BLOOD GLUCOSE TEST STRIPS) In Vitro Strip, 1 Strip by Apply externally route DAILY AS NEEDED (low sugar). Insurance preferred, Disp: 90 Strip, Rfl: 1
- Glucose Blood In Vitro Strip, 1 Strip by In Vitro route DAILY. One touch verio test strips, Disp: 100 Strip, Rfl: 1
- Insulin Syringe-Needle U-100 (ADVOCATE INSULIN SYRINGE) 31G X 5/16" 1 ML Does not apply Misc, 1 Each by Does not apply route EVERY 7 DAYS., Disp: 100 Each, Rfl: 0
- Lancets Does not apply Misc, by Does not apply route DAILY AS NEEDED (low sugar). Brand: insurance preferred, Disp: 90 Each, Rfl: 1
- Levonorg-Eth Estrad Triphasic (TRIVORA, 28,) 50-30/75-40/ 125-30 MCG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 28 Tab, Rfl: 0
- lisinopril (PRINIVIL, ZESTRIL) 20 MG Oral Tab, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- loratadine (CLARITIN, ALAVERT) 10 MG Oral Tab, Take 1 Tab by mouth DAILY., Disp: 30 Tab, Rfl: 0
- methotrexate sodium, PF, (MTX) 50 MG/2ML Injection Solution, Inject 0.5 mL beneath the skin EVERY SATURDAY., Disp: 12 mL, Rfl: 0

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Brown, Jennifer Lyn
 MRN: 340616, DOB: 10/26/1976, Sex: F
 Adm: 3/4/2020, D/C: 3/4/2020

EXHIBIT NO. B14F
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03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

- mometasone (NASONEX) 50 MCG/ACT Nasal Suspension, Spray 1 Spray in nose EVERY TWELVE HOURS., Disp: 1 Bottle, Rfl: 0
- ondansetron (ZOFTRAN ODT) 8 MG Oral TABLET DISPERSIBLE, Take 1 Tab by mouth EVERY EIGHT HOURS AS NEEDED for nausea., Disp: 30 Tab, Rfl: 1
- pantoprazole (PROTONIX) 40 MG Oral Tab EC, TAKE 1 TABLET DAILY, Disp: 90 Tab, Rfl: 1
- Probiotic Product (VSL#3) Oral Cap, Take 1 Cap by mouth DAILY 0700 on Empty Stomach. May increase to BID pm, Disp: 60 Cap, Rfl: 3
- sulfasalazine (AZULFIDINE) 500 MG Oral Tab, Take 3 Tabs by mouth TWICE DAILY., Disp: 120 Tab, Rfl: 2
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Inject 1 mL of Vit B12 IM every 30 days, Disp: 12 Each, Rfl: 0
- Syringe/Needle, Disp, 25G X 1-1/2" 5 ML Does not apply Misc, Inject 1 mL within a muscle EVERY THIRTY DAYS. Vitamin B12 IM, Disp: 12 Each, Rfl: 0
- Ustekinumab 90 MG/ML Subcutaneous Solution Prefilled Syringe, Inject 90 mg beneath the skin AS DIRECTED. Inject every 8 weeks. Indications: Crohn's Disease, Disp: 1 Syringe, Rfl: 5
- venlafaxine (EFFEXOR XR) 150 MG Oral CAPSULE SR 24 HR, Take 1 Cap by mouth DAILY., Disp: 90 Cap, Rfl: 1
- venlafaxine (EFFEXOR XR) 37.5 MG Oral CAPSULE SR 24 HR, Take 2 Caps by mouth DAILY., Disp: 180 Cap, Rfl: 1

Current Facility-Administered Medications:

- saline (OCEAN) nasal spray 0.65 %, 2 Spray, Nasal, Q2H PRN, Braslow, Matthew Lim, DO

Allergies

Allergen	Reactions
• Bee Stings [Bee Sting]	Swelling
• Oxycodone	Hives
• Remicade [Infliximab]	Rash
• Tape: Silk Or Adhesive	Rash

Plan of Care

Plan of Care Start Date: 03/04/20

Plan of Care Expiration Date: 06/04/20

Rehabilitative Prognosis: Poor

Planned Intervention(s): PT Eval Moderate Complexity (97162);Neuro Re-Education (97112);Therapeutic Exercise (Timed) (97110);Ultrasound (Timed) (97035);Manual Therapy (Timed) (97140);E-Stim (Commercial) (97014)

Frequency of Treatments: 1-2 times a week

Duration of Treatments: 3 months

History Components: Moderate (1-2 personal factors and/or comorbidities)

Examination of Body Systems/Components: Moderate (Addressing a total of 3 or more elements)

Clinical Presentation: Stable - unchanging or predictable (Low)

Clinical Decision Making (complexity): Low

Treatment Number: 1

Total Time of Evaluation: 30

Assessment: Essentially normal left knee clinical exam. Absent dysfunction.

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Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 3/4/2020, D/C: 3/4/2020

03/04/2020 - EVALUATION in RPH Physical Therapy (continued)

Other Provider Notes (continued)

No skilled physical therapy intervention recommended further than Home Exercise Program prescription.

Was Physical Therapy treatment performed at this visit?

Yes

Home exercise program was demonstrated during today's intervention as indicated below. Patient voiced understanding of instructions and willingness to comply. Patient performed a substantial amount of exercise to become familiar with movement control and mechanics. All questions were answered.

Access Code: BFHKCEKG

URL: <https://Guthrie1.medbridgego.com/>

Date: 03/04/2020

Prepared by: Jose Antonio Polo Traverso

Exercises

Prone Hamstring Curl with Anchored Resistance - 10 reps - 3 sets - 3 hold - 1-2x daily - 7x weekly

Hip Extension with Leg Straight - 10 reps - 3 sets - 3 hold - 1-2x daily - 7x weekly

Mini Squat with Chair - 10 reps - 3 sets - 3 hold - 1-2x daily - 7x weekly

Plan for Next Visit: Continue HEP as tolerated. Patient will contact this office for further exercise instruction if needed.

Evaluation Complexity Assessment: History Components: Moderate (1-2 personal factors and/or comorbidities)

Examination of Body Systems/Components: Moderate (Addressing a total of 3 or more elements)

Clinical Presentation: Stable - unchanging or predictable (Low)

Clinical Decision Making (complexity): Low

Treatment Number: 1

Total Time of Evaluation: 30

Total Number of Timed Code Treatment Minutes: 15

Caitlyn Martini, SPT was a participant during today's intervention, supervised at all times by Jose Traverso, DPT

Author: Jose Traverso, DPT 3/4/2020 11:14

Electronically signed by Traverso, Jose, DPT at 3/4/2020 12:04 PM



Brown, Jennifer Lyn

PAGE: 63 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/29/2020, D/C: 5/29/2020

05/29/2020 - XR GENERAL in Robert Packer XR

Imaging**Imaging****XR KNEE 3 VIEWS LEFT [173645423] (Final result)****XR KNEE 3 VIEWS LEFT [173645423]**

Resulted: 06/04/20 1215, Result status: Final result

Ordering provider: Altieri, Jennifer, NP 05/29/20 1046

Order status: Completed

Resulted by: Stuelke, Satre, MD

Filed by: Interface, Rad Results 06/04/20 1217

Performed: 05/29/20 1056 - 05/29/20 1113

Accession number: 6150460

Narrative:

Procedure(s): XR KNEE 3 VIEWS LEFT

Date of service: 5/29/2020 10:56 AM

Provided clinical information: 43 years, Female, "pain"

Procedure and materials: 3 images of the left knee and 2 images of the right knee were obtained.

Comparison studies: 1/22/2020.

Impression:

No acute findings.

Signed by Satre Stuelke, MD, MFA on 6/4/2020 12:15 PM

Acknowledged by: Altieri, Jennifer, NP on 06/04/20 1928

Indications

Left knee pain, unspecified chronicity [M25.562 (ICD-10-CM)]

All Reviewers List

Altieri, Jennifer, NP on 6/4/2020 7:28 PM



Brown, Jennifer Lyn

PAGE: 64 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 5/29/2020, D/C: 5/29/2020

05/29/2020 - XR GENERAL in Robert Packer XR

Imaging**Imaging****XR SHOULDER MIN 2 VIEWS RIGHT (STANDARD) [173645421] (Final result)**

XR SHOULDER MIN 2 VIEWS RIGHT (STANDARD) [173645421] Resulted: 06/05/20 1153, Result status: Final result

Ordering provider: March, Melanie E, FNP-C 05/29/20 1045

Order status: Completed

Resulted by:

Filed by: Interface, Rad Results 06/05/20 1155

Mingos, Mark, MD

Lynch, Michael T, RPA

Performed: 05/29/20 1055 - 05/29/20 1111

Accession number: 6148797

Narrative:

Procedure(s): XR SHOULDER MIN 2 VIEWS RIGHT (STANDARD)

Date of service: 5/29/2020 10:55 AM

Provided clinical information: 43 years, Female, Fell one week ago.

Right shoulder pain with range of motion.

Procedure: Standard protocol.

Comparison: None

Observations:

AP (internal and external rotation) and 45/45 degree views of the right shoulder were obtained. The medial portions of the clavicle and scapula are excluded. There is no evidence of acute fracture or dislocation. The glenohumeral and acromioclavicular joint spaces are maintained. No concerning focal osseous lesions are seen. There is a calcified granuloma in the right upper lung zone. The surrounding soft tissue structures and visualized right upper lung field are otherwise unremarkable.

Impression:

No acute osseous or joint space abnormality of the right shoulder.

Report transcribed by Michael Lynch, RPA/RA.

Urgency: Routine. This is a routine medical imaging report.

Recommendation: No specific imaging recommendation.

Mark Mingos has reviewed the images and preliminary report.

Signed by Mark Mingos on 6/5/2020 11:53 AM

Acknowledged by: March, Melanie E, FNP-C on 06/05/20 1215

Indications

Chronic right shoulder pain [M25.511, G89.29 (ICD-10-CM)]

All Reviewers List

March, Melanie E, FNP-C on 6/5/2020 12:15 PM



Brown, Jennifer Lyn

PAGE: 65 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/10/2020, D/C: 6/10/2020

06/10/2020 - EVALUATION in RPH Physical Therapy

Clinic Notes

Therapy Plan of Care

Traverso, Jose, DPT at 6/10/2020 11:48 AM

Author: Traverso, Jose, DPT

Service: REHAB

Author Type: Physical Therapist

Filed: 6/10/2020 11:52 AM

Date of Service: 6/10/2020 11:48 AM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

Cosigner: Stilwell, Mason, MD at

6/23/2020 4:08 PM

The Guthrie Clinic
Initial Evaluation Plan of Care
Outpatient Physical Therapy Services
ROBERT PACKER HOSPITAL
RPH PHYSICAL THERAPY
1 GUTHRIE SQUARE
SAYRE PA 18840-1625
Tel 570-887-4801
Fax 570-887-5830

Patient: Jennifer Lyn Brown

MRN: 340616

DOB: 10/26/1976

Date of Service: 6/10/2020

Referring Physician: Melanie March

Plan of Care Start Date: 06/10/20

Plan of Care Expiration Date: 09/10/20

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Left medial knee pain	719.46	M25.562

Rehabilitative Prognosis: Good

Goals: Pain: Patient will report decrease in left knee pain to 2/10 or less when performing sustained ambulation, stair climbing, walking dog, doing laundry.

Strength: Patient will demonstrate increased strength in left knee flexion and extension apparatus to >4/5 in order to support left knee loaded activity.

Gait: Patient will improve ambulation to tolerate > 1/4 mile without antalgic deviations.

Stairs: Patient will negotiate >10 stairs with reciprocal pattern.

Able to garden with minimal left knee pain

Planned Intervention(s): PT Eval Moderate Complexity (97162);Therapeutic Exercise (Timed) (97110);Manual Therapy (Timed) (97140);Ultrasound (Timed) (97035);Neuro Re-Education (97112);E-Stim (Commercial) (97014)

The above planned interventions may be used in Physical Therapy treatment of her condition, but will not be limited to these interventions as warranted by the Physical Therapist.

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Brown, Jennifer Lyn

PAGE: 66 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/10/2020, D/C: 6/10/2020

06/10/2020 EVALUATION in RPH Physical Therapy (continued)

Clinic Notes (continued)**Frequency of Treatment:** 1-2 times a week**Duration of Treatment:** 3 months

The Physical Therapy Plan of Care has been discussed with the patient. Patient concurs with Plan of Care, interventions, treatment, and goals.

I certify the need for these services furnished under this plan Physical Therapy treatment while under my care.

March, Melanie E, FNP-C

1 Guthrie Square

Sayre, PA 18840 (To be Electronically signed)

Author: Jose Traverso, DPT 6/10/2020 11:48

Electronically signed by Traverso, Jose, DPT at 6/10/2020 11:52 AM

Electronically signed by Stilwell, Mason, MD at 6/23/2020 4:08 PM



Brown, Jennifer Lyn

PAGE: 67 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/12/2020, D/C: 6/12/2020

06/12/2020 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Stahl, Matthew L, PTA at 6/12/2020 3:01 PM

Author: Stahl, Matthew L, PTA

Service: REHAB

Author Type: Physical Therapy Assistant

Filed: 6/12/2020 4:00 PM

Date of Service: 6/12/2020 3:01 PM

Status: Signed

Editor: Stahl, Matthew L, PTA (Physical Therapy Assistant)

The Guthrie Clinic

Treatment Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

570-887-4801

570-888-6666

Treatment Number: 2

Referring Physician: Melanie March

Primary Diagnosis:

	ICD-9- CM	ICD-10- CM
1. Left medial knee pain	719.46	M25.562

Insurance:

	excellus Effective 3/1/20 \$15 Copay 10 visits authorized Reference ID 000249660

Plan of Care Expiration Date: 09/10/20

Subjective Comments: Pt evaluated two days ago, no significant changes yet. Same medial knee pain at admission

Pain at Start of Care: 5/10

Pain at End of Care: 3/10

Interventions:

1099



Brown, Jennifer Lyn

PAGE: 68 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/12/2020, D/C: 6/12/2020

06/12/2020 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)**Cardiovascular Exercise:**

Number of Cardiovascular Exercise(s): 1

Cardiovascular Exercise 1

Equipment Used: Nu Step

Intensity: Level 5 for 5 min

Therapeutic Exercise:

Therapeutic Exercises (97110)

Number of Exercises?: 6

Total Minutes (all Therapeutic Exercise): 30

Number of Exercises?: 6

Exercise #1

Exercise Name: QS, SLR

Sets/Reps: 2x10

Exercise #2

Exercise Name: Sidelying hip abduction

Sets/Reps: 2x10

Exercise #3

Exercise Name: Bridges

Sets/Reps: 2x15

Exercise #4

Exercise Name: Mini Squats

Sets/Reps: 3x10

Exercise #5

Exercise Name: Leg Press

Sets/Reps: B/L: 60# x20, 100# 2x10

Education/Instruction:

Patient and/or caregiver was instructed in the following: Exercise recommendations and activity modifications

Assessment: Decreased knee pain noted from therapy today. Good tolerance to US and increased activity today. Reviewed HEP, pt doing well with this. Added leg press, no pain noted. Normal, non antalgic gait observed at all times. Full active knee extension, no lag with SLR. Pt instructed to avoid painful activities and pivoting on a planted foot.

Plan for Next Visit: Proximal strengthening, US as needed



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/12/2020, D/C: 6/12/2020

06/12/2020 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Time In: 1500

Time Out: 1530

Total Timed Codes (Minutes): 30

Total Treatment Time (Minutes): 30

Author: Matthew L Stahl, PTA 6/12/2020 15:33

Electronically signed by Stahl, Matthew L, PTA at 6/12/2020 4:00 PM



Brown, Jennifer Lyn

PAGE: 70 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/19/2020, D/C: 6/19/2020

06/19/2020 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Stahl, Matthew L, PTA at 6/19/2020 11:35 AM

Author: Stahl, Matthew L, PTA

Service: REHAB

Author Type: Physical Therapy Assistant

Filed: 6/19/2020 1:30 PM

Date of Service: 6/19/2020 11:35 AM

Status: Signed

Editor: Stahl, Matthew L, PTA (Physical Therapy Assistant)

The Guthrie Clinic

Treatment Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

570-887-4801

570-888-6666

Treatment Number: 3

Referring Physician: Melanie March

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Left medial knee pain	719.46	M25.562

Insurance:

excellus Effective 3/1/20 \$15 Copay 10 visits authorized Reference ID 000249660	
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Plan of Care Expiration Date: 09/10/20

Subjective Comments: No significant changes yet. Same medial knee pain. Pt compliant with her HEP, no adverse effects from this

Pain at Start of Care: 5/10

Pain at End of Care: 3/10

Interventions:



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/19/2020, D/C: 6/19/2020

06/19/2020 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)**Cardiovascular Exercise:**

Cardiovascular Exercise 1

Equipment Used: Upright Bike

Intensity: Level 5 for 5 min

Therapeutic Exercise:

Therapeutic Exercises (97110)

Total Minutes (all Therapeutic Exercise): 16

Exercise #1

Exercise Name: LAQ

Sets/Reps: 3x10 3 sec holds

Resistance: 5#

Exercise #2

Exercise Name: Standing hip abductions

Sets/Reps: 3x10 L+R

Details: tolerable

Exercise #3

Exercise Name: Bridges

Sets/Reps: 2x15

Exercise #5

Exercise Name: Leg Press

Sets/Reps: B/L: 60# x20, 100# 2x10; SL march 60# x20

Manual Therapy:

Manual Therapy (97140)

Soft Tissue Mobilization Details: US to medial knee

Total Minutes (All Manual Therapy): 8

Education/Instruction:

Patient and/or caregiver was instructed in the following: Exercise recommendations and activity modifications

Assessment: Slight decrease in medial knee pain when leaving therapy. Good tolerance to US and strengthening exercises, though increased medial soreness with WB activity. No pain in open chain. Able to add the upright bike, good mobility demonstrated with no discomfort. Pt encouraged to continue with her HEP. Normal gait observed, no antalgic patterns

Plan for Next Visit: Continue closed chain strengthening as tolerated, proprioception

Time In: 1136

1103



Brown, Jennifer Lyn

PAGE: 72 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/19/2020, D/C: 6/19/2020

06/19/2020 - FOLLOW UP in RPH Physical Therapy (continued)**Other Provider Notes (continued)**

Time Out: 1200

Total Timed Codes (Minutes): 24

Total Treatment Time (Minutes): 24

Author: Matthew L Stahl, PTA 6/19/2020 13:18

Electronically signed by Stahl, Matthew L, PTA at 6/19/2020 1:30 PM



Brown, Jennifer Lyn

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MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/23/2020, D/C: 6/23/2020

06/23/2020 FOLLOW UP in RPH Physical Therapy

Other Provider Notes

Progress Notes

Traverso, Jose, DPT at 6/23/2020 12:38 PM

Author: Traverso, Jose, DPT

Service: REHAB

Author Type: Physical Therapist

Filed: 6/23/2020 1:10 PM

Date of Service: 6/23/2020 12:38 PM

Status: Signed

Editor: Traverso, Jose, DPT (Physical Therapist)

The Guthrie Clinic

Treatment Note

Outpatient Physical Therapy Services

ROBERT PACKER HOSPITAL

RPH PHYSICAL THERAPY

1 GUTHRIE SQUARE

SAYRE PA 18840-1625

Tel 570-887-4801

Fax 570-887-6842

Treatment Number: 4

Referring Physician: Melanie March

Primary Diagnosis:

	ICD-9-	ICD-10-
	CM	CM
1. Left medial knee pain	719.46	M25.562

Insurance:

excellus Effective 3/1/20 \$15 Copay 10 visits authorized Reference ID 000249660	
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Plan of Care Expiration Date: 09/10/20

Patient Precautions: Obesity, anxiety, ADHD

Time In: 1230

Time Out: 1300

Total Session Minutes: 30

Pain at Start of Care: 3/10

Pain at End of Care: 3/10

1105



Brown, Jennifer Lyn

PAGE: 74 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/23/2020, D/C: 6/23/2020

06/23/2020 - FOLLOW UP in RPH Physical Therapy (continued)

Other Provider Notes (continued)

Subjective Comments: Absent new complaints at admission, improved tolerance to ambulation. Left knee pain still present, triggered after day activities.
No worse after today's encounter.

Interventions:**Cardiovascular Exercise (97110)****Number of Cardiovascular Exercise(s): 1****Time (minutes): 8**

Cardiovascular Exercise 1

Equipment Used: Upright Bike

Intensity: Level 5 for 8u min

Therapeutic Exercises (97110)**Total Minutes (all Therapeutic Exercise): 20**

Exercise #1

Exercise Name: Knee flexion and extension

Sets/Reps: 30# flexion and extension 3x10 ea

Resistance: 5#

Exercise #2

Exercise Name: Step downs on 6" box

Sets/Reps: 3x10 L+R

Exercise #3

Exercise Name: Sit to stand

Sets/Reps: 3x10

Assessment: Patient demonstrates absent acute left knee findings, non antalgic ambulation and transfers at all times. Skilled Physical Therapy services are required to address ongoing functional and objective limitations/impairments including sustained ambulation, standing activities.

Plan for Next Visit: Physical therapy intervention will emphasize therapeutic exercise, neuromuscular re-education, manual therapy, modalities to control pain as deemed appropriate.

Total UNTIMED Code Treatment Minutes:**Total TIMED Code Treatment Minutes: 30****Total Treatment Minutes: 30**

Author: Jose Traverso, DPT 6/23/2020 13:08

Electronically signed by Traverso, Jose, DPT at 6/23/2020 1:10 PM



GUTHRIE

Brown, Jennifer Lyn

PAGE: 75 OF 76

MRN: 340616, DOB: 10/26/1976, Sex: F

Adm: 6/23/2020, D/C: 6/23/2020

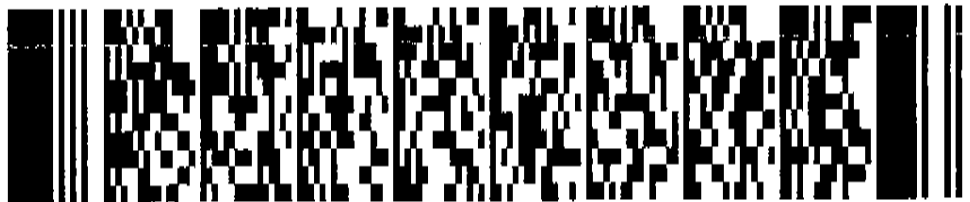
06/23/2020 - FOLLOW UP in RPH Physical Therapy (continued)

End of Report

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

877-304-5049



RQID:0000000000000000278425518 SITE:X02 DR:S
SSN:132582507 DOCTYPE:5032 RF:D CS:195d

Claimant: Jennifer Brown
SSN: 132-58-2507

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